INSTITUTE ON MENTAL DEFICIENCY I

January 23-24, 1957

INSTITUTE ON MENTAL DEFICIENCY II

January 25, 1957

UNIVERSITY OF MINNESOTA
Center for Continuation Study of the General Extension Divison
Minneapolis 14

INSTITUTE ON MENTAL DEFICIENCY I

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HELD IN COOPERATION WITH THE

DEPARTMENT OF PUBLIC WELFARE

UNIVERSITY OF MINNESOTA
Center for Continuation Study
of the
General Extension Division
Minneapolis 14

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Center for Continuation Study
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PROGRAM
INSTITUTE I

January 23, Wednesday

8:00 - 9:30 Check-in of Registrants. Dormitory Desk, Center for Continuation Study

State and County Responsibility for the Mentally Retarded and Epileptic
Presiding - Merritt Brown

9:30 - 10:00 Introduction......................Fred E. Berger, Merritt Brown
10:00 - 10:20 Legal Basis for the State's Program for the Mentally Deficient and Epileptic......................Mildred Thomson
10:20 - 10:40 Relationship Between the Welfare Board and the Central Office of the Department of Public Welfare......Ruby C. Benson
10:40 - 11:00 Relationship Between the Welfare Board and the Institution....................................E. J. Engberg
11:00 - 12:00 Discussion
12:00 - 1:30 Luncheon. Center Dining Room

The Retarded Child
Presiding - G. L. Wadsworth

1:30 - 2:00 Helping the Retarded Child Develop His Potentialities Through Case Work in the Local Community.........Dagny Johnson
2:00 - 2:30 Helping the Retarded Child Develop His Potentialities Through Development and Use of Local Facilities............... Mildred Ziegler
2:30 - 3:00 Helping the Retarded Child Develop His Potentialities Through Placement in an Institution............C. M. Henderson
3:00 - 3:30 Coffee
3:30 - 4:30 Discussion and Questions
Led by:...Verval Mueller

8:00 p.m.

The Role of the Physician in Planning for the Retarded Child
Moderator:......................Reynold Jensen

1. The responsibility of the medical profession for the mentally retarded and his parents..............Robert Bergan
2. When and how shall the physician interpret the mental deficiency of the child to his parents?..Franklin Mellencamp
3. How can the doctor utilize the services of the social worker in his relationship with the retarded child and his parents?..................................E. A. Kilbride

Discussion
Summary by the moderator

January 24, Thursday

Supervision for the Adult or Adolescent Employed or Employable

Presiding - Robert Boyer

8:45 - 9:00	Announcements	
9:00 - 9:30	What is Supervision	Frances Coakley
9:30 - 9:45	Institutional Preparation for Placement from Owatonna	Francis Stevens
9:45 - 10:00	Institutional Preparation for Placement from Faribault	Caroline Perkins
10:00 - 10:15	Institutional Preparation for Placement from Cambridge	Betty Lenz
10:15 - 10:30	Institutional Preparation for Placement from ADD	Ralph Rosenberger
10:30 - 10:50	Coffee	
10:50 - 11:10	Job Placement as seen by County Welfare Board	Harold F. Mickelson
11:10 - 11:30	Job Placement as seen by Vocational Rehabilitation	Ben Brainerd
11:30 - 12:00	Outline for Workshop for Afternoon Program	Fred E. Berger
12:00 - 1:30	Luncheon. Center Dining Room	
1:30 - 3:00	Workshops to discuss morning papers. Registrants will be divided into groups of from 15-20 with a chairman, recorder and resource persons for each group.	
3:00 - 3:20	Coffee	

Presiding - Robert Boyer

3:20 - 4:30	Five Minute Reports from Each Group Discussion	

INSTITUTE II

January 25, Friday

The Retarded, His Parents and the Community

9:00 - 10:30	Panel Discussion - Community Responsibility for the Adjustment of the Retarded Child	Moderator: Howard Huelster
	9:05 - 9:10 As Seen by a Parent	Pat Rogers
	9:10 - 9:15 As Seen by the School	Lettisha Henderson
	9:15 - 9:20 As Seen by the County Nurse	Esther Jacques
	9:20 - 9:25 As Seen by the Pastor	Michael McDonough
	9:25 - 9:30 As Seen by the Social Worker	Ardis Seifert
	9:30 - 10:30 Discussion Between Panel Members and General Discussion	
10:30 - 10:50	Coffee	

Determining a Child's Capabilities

Presiding - Donald Berglund

10:50 - 11:10	Mental Testing as an Aid in Determining Capabilities	Phyllis Amacher
11:10 - 11:35	Five Minute Discussions by:	Harriet Blodgett, Maynard Reynolds John Hawkinson, James K. Merrill, Mrs. Everett Taylor
11:35 - 12:00	General Discussion	
12:00 - 1:00	Luncheon. Center Dining Room	

Needs and Goals for the Mentally Retarded

Presiding - Ray Lappegaard

1:00 - 1:20 The Role of the Association for Retarded Children....Stanley Crist
1:20 - 1:40 Needs and Goals as Seen by a Parent....................John Holahan
1:40 - 2:00 Needs and Goals as Seen by the Department of Public Welfare.................................Morris Hursh
2:00 - 2:30 Discussion
2:30 - 2:45 Summary by Chairman

FACULTY

PHYLLIS AMACHER	Psychologist, Robbinsdale Public Schools, Robbinsdale
RUBY C. BENSON	Field Representative, Minnesota Department of Public Welfare
ROBERT BERGAN, M.D.	Practising Physician, Duluth
FRED E. BERGER	Director, Center for Continuation Study, University of Minnesota
DONALD BERGLUND	St. Olaf College, Northfield
HARRIET BLODGETT	Program Director, The Sheltering Arms, Minneapolis
ROBERT BOYER	Social Services Consultant, Division of Medical Services, Minnesota Department of Public Welfare, St. Paul
BEN BRAINERD	Division Director, Vocational Rehabilitation, Minnesota Department of Education, St. Paul
MERRITT BROWN	Director, Division of Field Services, Minnesota Department of Public Welfare
ELIZABETH CLESS	Program Consultant, Center for Continuation Study, University of Minnesota
FRANCES COAKLEY	Supervisor, Department of Welfare Services, Ramsey County Welfare Board, St. Paul
MERRILL K. CRAGUN	Course Coordinator, Center for Continuation Study, University of Minnesota
STANLEY CRIST	President, Minnesota Association for Retarded Children, Fairmont
E. J. ENGBERG, M.D.	Superintendent, Faribault State School and Hospital, Faribault
JOHN HAWKINSON	Supervisor, Bureau of Psychological Services, Minnesota Department of Public Welfare, St. Paul
LETTISHA HENDERSON	St. Paul Public Schools, St. Paul
JOHN HOLAHAN	Board Member, Minneapolis Association for Retarded Children, Minneapolis
HOWARD HUELSTER	Instructor in English, Macalester College, St. Paul
MORRIS HURSH	Commissioner, Minnesota Department of Public Welfare, St. Paul
ESTHER JACQUES	County Nurse, Steele County, Owatonna
REYNOLD A. JENSEN	Professor, Department of Pediatrics, University of Minnesota
DAGNY JOHNSON	Unit Supervisor, Medical Division, Hennepin County Welfare Board, Minneapolis
E. A. KILBRIDE, M.D.	Practicing Physician, Worthington
RAY LAPPEGAARD	Deputy Commissioner, Minnesota Department of Public Welfare, St. Paul
BETTY LENZ	Social Worker, Cambridge State School and Hospital, Cambridge

FATHER MICHAEL McDONOUGH	St. Olaf Catholic Church, Minneapolis
FRANKLIN MELLENCAMP	Practising Physician, Milwaukee, Wisconsin
JAMES K. MERRILL	Instructor in Social Work, Gustavus Adolphus Colleg and former School Social Worker, Koochiching County Welfare Board
HAROLD F. MICKELSON	Executive Secretary, Mower County Welfare Board, Austin
VERVAL MUELLER	Associate Professor, School of Social Work, University of Minnesota
J. M. NOLTE	Dean, General Extension Division, University of Minnesota
CAROLINE PERKINS	Social Worker, Faribault State School and Hospital, Faribault
MAYNARD REYNOLDS	Associate Professor of Educational Psychology, University of Minnesota
PAT ROGERS	Parent, Marshall, Minnesota
RALPH ROSENBERGER	Supervisor of Defective Delinquents, St. Cloud Reformatory for Men, St. Cloud
ARDIS SEIFERT	Child Welfare Worker, Blue Earth County Welfare Board, Mankato
FRANCIS STEVENS	Child Care Supervisor, Owatonna State School, Owatonna
MRS. EVERETT TAYLOR	Member, Minneapolis Association for Retarded Children, Wayzata
MILDRED THOMSON	Supervisor, Section for Mentally Deficient and Epileptic, Minnesota Department of Public Welfare
G. L. WADSWORTH, M.D.	Superintendent, Cambridge State School and Hospital, Cambridge
MILDRED ZIEGLER	Case Worker, Kanabec County Welfare Board

****

IN CHARGE OF EXHIBITS	Shirley Bengtson, Donna Mae Danielson

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Institute on Mental Deficiency I

January 23 - 24, 1957

Registrants

Anderson, Ellen	818 North Main Cambridge, Minnesota
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Birkeness, Valborg	1396 McKinley St. Paul, Minnesota
Blager, Mildred B.	2219 South Bryant Minneapolis, Minnesota
Bloedow, Gerald A.	215 Third Street Northwest Faribault, Minnesota
Boswell, George M.	Route 2 Stanchfield, Minnesota
Burch, Mary	Redwood Falls, Minnesota
Carlson, Evelyn	16400 Wayzata Boulevard Wayzata, Minnesota
Carlson, Ruth M.	1764 Dayton Avenue St. Paul, Minnesota
Carpenter, Robert L.	758 West Broadway Winona, Minnesota
Clark, Virgilia Moats	1014 North Fourth Avenue West Grand Rapids, Minnesota
Cote, Arthur J., Jr.	656 - 40th Avenue Northeast Minneapolis, Minnesota
Damkroger, Genevieve	5106 Lyndale Avenue South Minneapolis, Minnesota
Dombovy, Irene G.	Benton County Welfare Office Foley, Minnesota

Mental Deficiency I

Egloff, Frances	638 Oakwood Drive Anoka, Minnesota
Ellenson, G. M.	Walker, Minnesota
Farrell, Eugene M.	Preston, Minnesota
Ferrier, Florence	Thief River Falls, Minnesota
Field, V. A. (Mrs.)	919 Linden Fergus Falls, Minnesota
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Fjetland, Elizabeth	Station A Faribault, Minnesota
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Fridner, Aileen E.	501 Swift Avenue South Litchfield, Minnesota
Frissell, Georgia M.	724 Knight Avenue Thief River Falls, Minnesota
Fuller, Warren	180 Sixth Avenue Granite Falls, Minnesota
Gappa, Dorothy Ann	1109½ Tenth Avenue North St. Cloud, Minnesota
Hagen, Harald L.	2514 - 13th Avenue South Minneapolis 4, Minnesota
Halvorsen, Howard	Walker, Minnesota
Hammarberg, A. Luella	Vasa Children's Home Red Wing, Minnesota
Hanrahan, Thomas E.	Route 2 Aitkin, Minnesota
Hanson, Eleanor	Bagley, Minnesota
Haugan, James E.	Benson, Minnesota
Hofmeister, Donald	227 West Fourth Winona, Minnesota

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Hybertson, Audrey	425 East Seventh Street Blue Earth, Minnesota
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Johnson, Harold	806 S. Division Northfield, Minnesota
Johnson, Martha O.	6936 Thomas Avenue South Minneapolis 23, Minnesota
Karlins, Miriam (Mrs.)	2764 Drew Avenue South Minneapolis, Minnesota
Kiernan, Daniel	405 Eighth Street Northeast Buffalo, Minnesota
Kim, Shin H.	2966 Kentucky North Minneapolis, Minnesota
Kjenaas, Nancy K.	2307 Pleasant Minneapolis, Minnesota
Klodt, Janice Ann	610 - 24th Avenue South Minneapolis, Minnesota
Kooiker, Meinard S.	134 Court House Minneapolis, Minnesota
Kubrior, Ann	1110 Smith Avenue Worthington, Minnesota
Laman, Virginia	1225 Fourth Avenue Windom, Minnesota
Larson, Thelma	846 Laurel Avenue St. Paul 4, Minnesota
Leahy, John J.	Ortonville, Minnesota
Lofboom, Olive M.	Harris, Minnesota
Lugtig, Donald J.	2721 Bixby Avenue Bemidji, Minnesota
Lundstrom, Muriel	Lindstrom, Minnesota

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Markeseth, Oscar L.	Madison, Minnesota
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Nelson, Hattie	Cambridge, Minnesota
Nelson, Lucile	407 South First Willmar, Minnesota
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Farrell, Eugene M.	Preston, Minnesota
Ferrier, Florence	Thief River Falls, Minnesota
Field, (Mrs.) V. A.	919 Linden Fergus Falls, Minnesota
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Carlson, Ruth M.	1764 Dayton Avenue St. Paul, Minnesota

Gappa, Dorothy Ann	1109½ 10th Avenue North St. Cloud, Minnesota
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Gernand, (Mrs.) Edward	104 North Oak Alexandria, Minnesota
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Hanson, Eleanor	Bagley, Minnesota
Hanson, Judith	21 Lind Street Faribault, Minnesota
Haugan, James E.	Benson, Minnesota
Hawk, Josephine S.	Lake Wilson, Minnesota
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Johnson, (Mrs.) William R.	R. F. D. 4 Alexandria, Minnesota
Johnston, (Mrs.) Hugh C.	712 Greenvale Northfield, Minnesota
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Lauer, (Mrs.) Andrew	Olivia, Minnesota
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Lofboom, Olive M.	Harris, Minnesota
Lugtig, Donald Joseph	2721 Bixby Avenue Bemidji, Minnesota
Lundstrom, Muriel	Lindstrom, Minnesota
McCurdy, Beverly	Redwood Falls, Minnesota
McGuire, Paul T.	1005 Morgan North Minneapolis, Minnesota
McKee, G. W.	Box 368 Excelsior, Minnesota
Madow, Arnold A.	Station A Faribault, Minnesota
Markeseth, Oscar L.	Madison, Minnesota
Martinson, Ruth C.	803-10th Street Worthington, Minnesota
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Mehlhop, Caroline	Glencoe, Minnesota
Mercer, Mary L.	Owatonna State School Owatonna, Minnesota
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Nelson, Hattie	Cambridge, Minnesota
Nelson, Lucile	407 South First Willmer, Minnesota
Nystrom, Ruth	141 Twentieth Avenue North St. Cloud, Minnesota
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Paffrath, (Mrs.) R. W.	Dawson, Minnesota
Pearson, Edith F.	146 North Bridge Street Albert Lea, Minnesota
Perkkio, Mildred J.	Route 2, Box 163 Mound, Minnesota
Petersen, Elizabeth Brewer	Lake Benton, Minnesota
Peterson, Milton M.	1305 Carlton Avenue Cloquet, Minnesota
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Smith, Shirley	Victoria Heights Alexandria, Minnesota

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Wilson, (Mrs.) Maitland	Springen Fergus Falls, Minnesota
Zehnle, Julia	Long Prairie, Minnesota
Ziegler, Mildred E.	Mora, Minnesota

LEGAL BASIS FOR THE STATE'S PROGRAM FOR THE MENTALLY DEFICIENT AND EPILEPTIC

Mildred Thomson

The program for this institute is not general information, it is not of a theoretical nature; rather, it is related specifically to Minnesota and what is done for retarded persons here. The participants are all persons concerned in some way in Minnesota's program - University staff members, parents, professional staff from welfare boards and the Department of Public Welfare, and from some other agencies with an interest in the mentally retarded. Thus this institute is Minnesota - or rather the Department of Public Welfare - taking stock of itself, telling what has been done and how. Then, more important, how there may be improvement in the future! We are in reality conferring together - not asking experts to come and give us final answers.

Because the program for the institute is of this type, the planning committee felt there should be a statement of the legal basis for what is done - that is for what is done on the state level by the Commissioner or his representatives, and what is done on the local level by the welfare board, represented by the executive secretary or caseworker. The department program is to a great extent determined by the legislature, not only by the amount of appropriations, but by the laws passed. These in reality determine broad policies by establishing duties, providing for authority, fixing responsibility, and setting limits. In discussing basic laws I shall confine myself to those administered by the Department of Public Welfare and county welfare boards.

At the first meeting of the territorial legislature in 1851 there was discussion of plans for mentally retarded persons who needed care out of the community. It was not until 1905, however, that an institution at Faribault was established as a separate facility caring only for the mentally deficient. (At that time the term feeble-minded was used, now mentally deficient and mentally retarded are used interchangeably.) Every institution since that date has also been established by law and its general purpose defined. The institutions are an integral part of the Department of Public Welfare's program for the mentally retarded. Representatives of the institutions are present here and will give some idea of the laws under which they function as they relate some of their activities.

The laws, however, which make possible a "state-wide" program for the mentally retarded and require the participation of welfare boards were passed in 1917 as part of a group of more than 30 laws for the protection of children. These provided for the Board of Control to administer the laws and for county child welfare boards to function locally under Board of Control direction. They also included a law making possible commitment of the mentally deficient, child or adult, to the guardianship of the Board of Control. Some quotations from these laws will be helpful in showing that from that time there has been a definite legal basis for a very comprehensive program for the mentally retarded.

First the responsibility of the Board of Control:

4456. <u>Duties of the Board of Control in behalf of children - Executive Officers. -</u>

It shall be the duty of the board to promote the enforcement of all laws for the protection of defective, illegitimate, dependent, neglected and delinquent children, to co-operate to this end with juvenile courts and all reputable child-helping and child-placing agencies of a public or private character, and to take the initiative in all matters involving the interests of such children where adequate provision therefor has not already been made.

The Board of Control is then authorized to appoint county child welfare boards if requested to do so by the county commissioners. It then says: "The child welfare board <u>shall</u> perform such duties as may be required of it by the said board of control in furtherance of the purposes of this act," etc. Since the defective child was one whose interests must be protected by the Board of Control, the county child welfare board was also responsible for his welfare, and from the earliest time the adult retarded were considered "children" for the purposes of this law. It is because of these laws that in Minnesota the welfare of the mentally retarded has been inextricably tied into a local program of community planning.

The guardianship law made possible the filing of a petition with the probate court of the county for a hearing to determine mental deficiency. The board was composed of the judge and two doctors appointed by him. "If the person examined is found to be feeble-minded, the court shall order him committed to the care and custody of the State Board of Control, as guardian of his person."

The original guardianship law did not spell out what "care and custody" implied. The only specific authority stated was that the Board of Control could place a ward in an appropriate institution when such placement was needed. However, by 1923 it was recognized that if the mentally retarded were to be served there must be more specific authority, and thus responsibility. The law therefore authorized the Board of Control after commitment of a person to guardianship "to exercise general supervision over him anywhere in this state, outside any institution through any child welfare board or other appropriate agency thereto authorized by said board of control."

Thus the basic laws - responsibility of state and county child welfare boards, guardianship, supervision! Since they were passed nearly 40 years ago one might well ask if they have not been drastically changed. The answer is that the changes have been almost entirely in providing more specific measures for carrying out the intent of the laws. Also, in 1935 epileptic persons were included with the mentally deficient in the guardianship law. The basic content of the laws embodying fundamental philosophy have not been changed. Time today does not permit going into the many laws added to the original basic ones, such as provision for using the sheriff for transportation to an institution or providing procedures for removing guardianship. This lack of change in the basic philosophy of the laws underlying the program will be seen by reviewing the laws as they are stated in the General Statutes of 1953.

> Minnesota Statutes 1953 393.07 POWERS, DUTIES. Subdivision 1. Act as county welfare board. After its establishment the county welfare board shall forthwith assume the powers, duties, and responsibilities of the county child welfare board, if any, existing in the county, and shall perform such duties as may be required of the county child welfare board or by law or by the commissioner of public welfare with regard to the enforcement of all laws for the protection of defective, illegitimate, dependent, neglected, and delinquent children.
>
> Minnesota Statutes 1953 525.753 COMMITMENT.------------------- Subd. 2. Director appointed guardian of person; commitment to director. If the patient is found to be mentally deficient or epileptic, the court shall appoint the director guardian of his person and commit him to the care and custody of such director.
>
> Minnesota Statutes 1953 525.762 DETENTION.--------------------- Subd. 2. Upon commitment of a mentally deficient or epileptic patient, the director may place him in an appropriate home, hospital, or institution or exercise general supervision over him anywhere in the state outside of any institution through any child welfare board or other appropriate agency thereto authorized by the director.

The 1953 session of the legislature created the Department of Public Welfare and the position of the Commissioner of Public Welfare, definitely vesting in the Commissioner all of the responsibilities of the previous Director of Social Welfare and the Director of Public Institutions. Since these in turn had taken over the responsibilities of the Board of Control, the Commissioner quite definitely has the responsibility imposed upon the Board of Control in 1917. At that time the Board of Control was directed to "take the initiative in all matters involving the interests of such children where adequate provision therefor has not already been made." This directive to the Board of Control must be considered in interpreting the first of the 1953 statutes quoted above. Certainly the intent of the law is to provide protection for children who need it. If that is so, here is authority and responsibility for aiding parents to determine what are the resources for their children and so know which ones or which laws they wish to use. Also, here is a legal basis for promoting all types of community organization and activity which are for the best interests of the retarded. However, very frankly, the state has failed in the past to give the leadership it should give in this field. I am glad to tell you, however, that Federal funds have been secured which will make possible an addition to the staff of the Section for the Mentally Deficient and Epileptic. The purpose of the new job is to aid in the promotion and organization of community activities for the retarded.

Second comes the commitment law. I have only quoted the final action of the judge. It is true that neither here nor earlier in the law is there any statement indicating that the welfare board must assist the family in planning for the hearing. However, guardianship is a law for the protection of the retarded and aiding parents to conform to legal procedures is part of the process of "promoting the enforcement." Thus the Commissioner requests or requires that the welfare board give this service.

The third stage in carrying out these basic laws is giving supervision. You may note that in the wording of the law there is not a <u>shall</u> for the Commissioner here, but the 1917 law authorizing the Board of Control to promote the enforcement of laws to protect children did say: "It shall be the duty," etc., and today if the Commissioner is to carry out his responsibilities he must see that supervision is given. The intent of the law saying the Commissioner "may" give supervision is certainly to place the responsibility upon him. And it is accepted as a requirement set by the legislature. Therefore, he again uses the authority given in the first of the three previous quotations and <u>requires</u> that the actual acts of supervision be given by welfare boards. The Section for the Mentally Deficient and Epileptic acts for the Commissioner in carrying out these basic laws. You will be glad to know that with the assistance of some county welfare board caseworkers the Department is rewriting the manual for welfare boards. Providing a manual as an aid and guide to welfare boards is certainly a <u>must</u> for the department.

I have emphasized the words <u>requires</u> and <u>shall</u> because we, the state and welfare boards, must all remind ourselves that it is our duty and responsibility to develop a community program for the retarded and to cooperate with all other agencies in doing this. We must make certain that we, the state and welfare boards, "take the initiative in all matters involving the interests of such children where adequate provision therefor has not already been made." It is our duty to help families place a child under guardianship if they so desire in order that they have the advantage of supervision by the welfare board. It is our duty to provide supervision, and this means helping an individual make the best possible adjustment with the potentials which he possesses. These laws provide for a general program which is broad and comprehensive, but then require individualization as regards the wards.

Just here it is well to state that the responsibility of the Commissioner includes authority to be used to remove a ward from the community and place him in an institution when it is necessary to protect him or to protect the community from his actions. When this is necessary it is really a part of the supervisory process.

The program for the mentally deficient and epileptic is a must for the state and the county welfare boards; the state to set policies, give leadership and counsel, and make certain that supervision is given. The welfare boards actually do the job! If we on the state level do not give the leadership and help we should, we are falling down on a shall job. If you in the counties do not provide supervision and give local leadership, you are falling down on a shall job. We in the state office appreciate the fine job the welfare boards have done, but count on an even greater response to the demands made by law and by the Commissioner. Together I am sure we will resolve that 1957 will see the best interpretation and administration of the laws since the first ones were enacted in 1917.

RELATIONSHIPS BETWEEN CENTRAL OFFICE AND COUNTY WELFARE BOARDS

Ruby C. Benson

When I started to think about the subject that had been assigned to me to talk about at this session I discussed it with Miss Thomson to learn if I should talk about the history of developing a relationship which exists between the Central Office and the county welfare boards or if there was some other approach that she might like to suggest. Miss Thomson said that when the program had been planned time had been allowed for a discussion period and in order to stimulate some thinking, so that there will be participation from the group here, she suggested that I present to you some of our policies and procedures as they relate to our relationships. You may wonder before I finish reading this paper whose side I am on but being a field representative from the Central Office my job is one of being the liaison or "in between person" between the Department of Public Welfare and the County Welfare Boards. When the policies of the Department do not seem to be working out the way the county agency feels they should I try to bring back your criticisms or suggestions to the Central Office. Likewise if the Section on Mentally Deficient and Epileptic feel that some county is not administering a policy correctly I may be asked by Miss Thomson to help explain it to the Executive Secretary of the Welfare Board or give some explanation at a board meeting.

The staff of the Mentally Deficient and Epileptic Section together with a committee of county workers and State personnel is currently in the process of reviewing and rewriting the manual material. Some of you may have some suggestions you will want to give which may help us strengthen our policies and procedures. Perhaps some of you have feelings about the experiences you have had in trying to work with some of the policies and would like to share these experiences with others who are trying to give the same kind of case work service. I feel that this institute gives us an opportunity to learn to know one another better, to discuss the mutual problems we have and thereby help to continue the good working relationship that has been established.

A bulletin was recently sent to all county welfare boards which gave a Social History outline for Mentally Deficient and Epileptic referrals. This social history outline was developed with the assistance of staff members from the institutions, social workers from Hennepin, Ramsey and several rural counties and from the field staff. The outline is in topical form since it was felt that this type of recording is the most useful and practical way of making the case material readily accessible to the Section on Mentally Deficient and the Institutional personnel who will be using the referral material. The Central Office must depend upon the county welfare board, who acts as an agent of the Commissioner of Public Welfare, to provide the social history. The Central Office would like to have this referral history before the court hearing so that if there is any question about proper planning for this person suggestions might be given for some other plan. Some people question why the Central Office should have a study until after the person has been committed to the Guardianship of the Commissioner of Public Welfare since it is felt that the determination of mental retardation or epilepsy is one to be determined by the court. Social histories are sometimes delayed in reaching our office until long after the court order of committment has been sent by the court. These histories serve as a working tool and the more complete the history is the better understanding there is of the case by the Central Office and institutional staff members who must use it in trying to help work out a satisfactory plan for the ward.

County Welfare Boards are delegated with the responsibility of giving supervision to mentally deficient and epileptic wards who reside in the counties. The Commissioner of Public Welfare, through the Section for the Mentally Deficient and Epileptic, should have periodic reports on these wards so that he, as guardian, knows that supervision is being given and that information is currently available to him. Some caseworkers find some of these supervisory visits hard to make and do not think that they are purposeful. They will say that the family of the committed ward understands the purpose of guardianship, that they are stable adequate parents and would not want their child to go to an institution until they could no longer give care in their own home. The caseworker wonders what there is to do in this situation. Perhaps because of heavy caseloads and staff shortages these cases are not visited for long periods of time. If a caseworker could visit a family shortly after the committment, when there would be questions about the committment procedure, help lessen the fears they may have and share their experiences with them, a better relationship might be established earlier with many families. It is hard to believe that a family with an epileptic, mentally retarded or any other type of handicap would not welcome an opportunity to discuss their particular problem with a person skilled in understanding and in helping them talk things through. They need a friend who understands. This is where the Friends of the Mentally Deficient have been helpful to other parents and to caseworkers. Unfortunately, not all counties have this organization but it is hoped that more and more groups will be organized. Some welfare boards will keep the Central Office informed about the progress of wards regularly, while others will delay until there is a crisis.

Questions arise about the necessity of sending reports that relate to plans for wards living in the institutions directly to the Central Office. It is felt that correspondence could be directly with the institution with copies of the correspondence to the Central Office. Some feel that progress reports on wards should be sent to the Central Office directly by the county of residence rather than by the county of committment. Reports must be adequate so that the Commissioner of Public Welfare can be assured the wards are being given services that are acceptable. There are times when pressures are brought to bear upon the Central Office by a community when it is requesting an emergency placement. In our relationship with county welfare boards we have to depend on it for all of the information that it can provide in being able to give a decision that is based on fact back to the community. Because institutional space is so limited it is only in extreme emergencies that exceptions in admission are made.

Many counties have done outstanding work in making plans for wards who have returned to the community from the institution. The Welfare Board has this responsibility of making a plan for the ward when the Central Office states that a ward is ready for placement. It does not, however, feel that a ward should be placed until there is a definite plan that has possibilities of success. County Agency caseworkers find it difficult to know where to start in trying to find a place for a ward to work or live unless there is an adequate referral history from the institution who knows the persons abilities, his personality, his personal habits, his social adjustments, perhaps a picture of the ward and anything else that would be necessary for a successful placement. I am thinking of a ward who was returned to a county where little was known about him excepting that he could work in a shoe repair shop. His work record was good but little was known about his social or personal habits so there was difficulty with the living arrangements that had been made and with his selection of friends. It is always helpful to know if a boy is to be placed on a farm, what kind of work he can do for a farmer. If he can operate a tractor can he merely drive it, or can he also maintain it. If he can operate a tractor what type of tractor is it? If a boy or girl can be employed in a laundry, what kind of work are they familiar with in this setting? Then there is the information that is necessary about money. Has the ward had any experience in handling money, can he buy any of his own clothing, would an employer be apt to exploit him, what are his sense of values? All of this information would be helpful to the caseworker who must make a plan and later supervise the ward in the community.

Sometime ago we had difficulty in our relationships between the Central Office, county welfare boards and parents because of our policies on vacations and visits from institutions. These policies have been reviewed and adjusted so that there seems to be more satisfaction. It is necessary that the Commissioner of Public Welfare establish policies and procedures so that there is uniformity in administration and that health considerations be safeguarded. Recommendations of County Welfare Boards are essential in planning and approving vacations and visits for wards.

The question of restoration to capacity and discharge of guardianship often comes up in state-county relationships. A caseworker will have the experience of supervising a mentally deficient ward over a period of years and be firmly convinced that because of his good adjustment, socially and economically, that he be recommended for discharge of guardianship. A report with the recommendation of the welfare board for discharge of guardianship is sent to the Central Office. A letter comes back recommending another psychological test before a petition for discharge or restoration to capacity can be considered. When the caseworker asks the ward if he will be willing to have a psychological examination he does not want to cooperate and he continues to remain a state ward. Before the Central Office can recommend discharge of guardianship or restoration to capacity the Commissioner of Public Welfare must have sufficient proof that would support this discharge in court. The report from the county welfare board must give the whole adjustment of the individual and show whether, in the opinion of the agency, he can get along in a satisfactory manner without supervision. The Section on Mental Deficiency and Epileptic represents the Commissioner of Public Welfare in making this decision and has the responsibility to council the county welfare boards in what is thought to be in the best interests of the ward.

There has been a law in effect for many years in this state which provides that license to marry cannot be issued to mentally deficient or epileptic wards. Some people wonder if this law should not be reconsidered so that under certain conditions marriage might be legal. I am sure that there are caseworkers here who have felt like I did when I was a child welfare worker in a rural county. I would hear that one of the mentally deficient wards that I had been supervising had gone to another county, gotten a marriage license and had been married, I sometimes secretly felt that marriage was a good thing for the ward because it helped the person become more stabilized, but I had a feeling of guilt because I knew that it was legally and administratively wrong.

Relationships that are well established are necessary when the county welfare board and the Central Agency must give supportive help to one another when criticisms come on the service given a ward, explanation of policies and procedures to community groups who may not be understanding and in dealings with other phases of the program. County welfare boards are asked to give many services, one of which is the service to the mentally deficient and epileptic. I am afraid that many times we fail to give you words of appreciation that you have coming for the splendid work you are doing. Because of the relationships that have been established I hope that together we can work toward developing better resources for the care of the mentally deficient and epileptic and continue to give the kind of casework service that will make happier lives for these people.

RELATIONSHIP BETWEEN THE WELFARE BOARD AND THE INSTITUTION

Edward J. Engberg

If you have not already noticed it, our general subject for this morning's program makes no mention of the responsibility of state institutions for mental defectives but only those of the State and County. I assume that the members of the Planning Committee for these institutes were so well satisfied with the institutional aspects of the treatment, education and care being currently provided that the recital of their responsibilities was considered unnecessary. Or is this wishful thinking? Seriously, I am glad to have been asked to discuss the relationship between the Welfare Board and the Institution as this is a matter of great importance to the patient during the period of residence in an institution, whether it be in Faribault, Cambridge, Owatonna, the Annex for Defective Delinquents, or in the Shakopee or Lake Owasso Children's Homes.

We endeavor to make life for all patients as happy and satisfying as possible, to encourage a healthy attitude toward others, to develop self-respect and self-reliance with a feeling of pride in their work. Visiting by relatives and desirable friends is, therefore, encouraged as are vacations in the family home. The County Welfare Board and Institution must work together closely in these relationships. The institution may question the advisability of some former friend visiting or writing to the patient and in such cases a decision often can be made through correspondence with the Welfare Board.

Vacation plans are made jointly by the welfare board and the institution including special arrangements, when necessary, such as proper diets, tests of urine for sugar, and supervision by a local physician for diabetics or continuing anti-convulsant medicines without interruption for those subject to such attacks. There always is an understanding that a patient should be brought back to the institution if not doing well while on vacation. It happens occasionally that a patient returns in an unsatisfactory condition from a vacation. That fact is reported to the Welfare Board by the institution to try to determine the reason and in order that careful consideration be given before approving another vacation in the home. It may happen occasionally that a family complains to the Welfare Board about some condition they observed after the patient came home or that they observed while visiting at the institution but had not discussed with anyone in authority while there. The Welfare Board then informs the institution of such questions or complaints so that porper attention may be given.

The institution routinely keeps the welfare board posted on all important matters that concern the patient, such as a serious illness or accident, unauthorized absence, the need of a surgical permit if an operation is believed to be necessary, or of transfer to another institution.

This information is provided through letters to the welfare board with copies to the Central Office or by copies of letters to the patient's correspondent or by telephone in an emergency.

Occasionally following admission, especially in the case of brighter patients, they feel very hostile and will blame the County Case Worker for their having been brought to the institution. In time this feeling tends to be changed and to disappear. We believe it is very important that the welfare board staff keeps in touch with the patient, even if the stay is a long one, so that when the time does come to make plans for community placement that a friendly and understanding relationship exists. This will be emphasized, I am sure, by the speakers tomorrow morning discussing the topic "Supervision for the Adult or Adolescent Employed or Employable." Good planning for this important group and their supervision requires effective co-operation between institutions, county welfare boards, relatives of patients concerned, rehabilitation and employment services and of the Department of Public Welfare.

HELPING THE RETARDED CHILD DEVELOP HIS POTENTIALITIES THROUGH CASE WORK IN THE LOCAL COMMUNITY

Dagny Johnson

My topic, "Helping the Retarded Child Develop His Potentialities Through Case Work in the Local Community," seems to me to signify a present day approach and point of view. I find in this statement exceedingly important and exciting implications. One is that the mentally subnormal child has a place in the community. Another implication is that this child as well as his parents can profit from the case work approach. And a third is that the caseworkers own goal in relation to the retarded child is to find and develop individual potentialities rather than to help carry out a preconceived plan.

Perhaps more and more the community is coming to believe that intellectual ability is not nearly as important a determinate of success in life as it was once thought to be. More of us are coming to the realization that whether or not a mentally handicapped child has a place in the community does not depend on his intellectual endowment as much as upon his relationships to the community and to his family. The interest of the community becomes most appropriate and meaningful when we learn that "both the child and his family react in large measure according to community expectations."[1] This means that the large number of children who are in their own homes can more frequently adjust happily within their family groups because the community has shown willingness to share a responsibility for these children. Evidence of greater willingness is seen in growth of community resources for the retarded. Perhaps the community was and is waiting for help in understanding the problems presented by the retarded child. Certainly in this community we cannot overlook that parents groups have affected many of these changes without which a retarded child and his family face tremendous odds in the community.

A change in community thinking is one reason why we are being offered the challenge of making a greater contribution in behalf of the retarded child. As we face this challenge we find that we need to examine our skills and knowledge and ask ourselves what we know about the retarded child on which we may base our contribution. It would seem that broadly speaking our goal for the retarded child as for all children might very well be a healthy personality. We know that some of the most basic components of a healthy personality for any child are a sense of trust, a sense of autonomy or independence, a sense of initiative, a sense of accomplishment and a sense of identity.[2] We know that they are ideally integrated in overlapping a somewhat flexible stage of development. We know well the hazards in the early years of life for any child to achieving these components of a healthy personality. No two children achieve them at the same rate or to the same degree and that there are infinite ways in which children can vary and still have healthy personalities. It then becomes obvious that children who differ in intellectual endowment as well as children who differ in other ways have superimposed hazards to a healthy personality. Therefore we can assume that an exceptional child needs even more resourceful, patient and imaginative help than other children in order to achieve the components of a healthy personality. Because additional demands may be made on parents who have all they can do to understand and to meet the needs of a so-called normal child, help is urgently needed. Both child and parent need more help but instead have been given less help by us and by the community. A fact finding report of the Mid-century White House Conference on Children and Youth further clarifies that "actually children with orthopedic, visual, auditory, intellectual or other limitations suffer, sometimes to exaggerated degree, from certain deprivations and problems that are more or less common to all children." Examples of deprivations are loss of social contacts, decreasing outlet for pent up emotions in physical activity, deprivation or decrease in opportunity to live in childlife situations, and problems of dependency and rejection - self-rejection, rejection by their peers, by their parents and by the wider social community.[3] These then are threats to a healthy personality which can be avoided or decreased through case work efforts when we seek to increase a child's potential for being a happy contributing human being. When we evaluated a particular child's problem and found it to be mainly more intense and more complex than those of other children we know it is possible to use old as well as new techniques of helping solve problems.

You may have wondered why I did not begin by stating which retarded children we can help as you are all aware that some of them are so severely retarded there seems to be little or no response. I should like to give some reasons why I must even in this respect leave it up to you to decide case by case how you can help or cannot help. One of the most significant contributions to our knowledge of children is John Bowlby's World Health Organization report on Maternal Care and Mental Health. He presents evidence that unless the young child receives adequate stimulation at appropriate times certain capacities will not develop or a capacity may atrophy.[4] This indicates to me that we have a preventive role to which we must be alert. It is a challenge to you, to parents and to boarding mothers caring for helpless children to use every means known to stimulate children to develop even limited capacities. We are further encouraged to individualize when we read that epidemiologists confirm our own experience that there are constantly appearing cases that do not abide by the rule that once a mental deficient always a mental deficient. Dr. Paul V. Lemkau in discussing epidemiological aspects also reports that differences in opportunity and motivation account for more mental deficiency in the lower socio-economic groups of the population.[5] If we need further encouragement to feel this is not a hopeless cause, we have but to read Howard R. Kellman's statement that mental retardation is a symptom of a variety of processes with differing causes and sources. The end product varies in kind and intensity and is neither static or fixed, but changes with time and with changed social opportunities, social expectations, and treatment. Mr. Kellman sees clinics as a means not only of giving practical and immediate assistance to the child and family but also of restoring the child's status as a human being.[6]

When it is possible to work directly with the child or when we have the opportunity to teach a parent to do so we may do well to consider Ruth Smalley's urging that we find, "A way to connect with the powerful purposive force that is the child himself, in order that he may use us to accomplish a freshly discovered and freshly chosen social purpose."[7] We need to approach our client not as a helpless victim but as an individual who can act in the drama of solving his problems. There is no motivation toward finding a solution when one regards ones self as a victim, but there is motivation and achievement for him in doing his part toward gaining a happier and more satisfying life.

When a child is in his own home it is not of course possible to give lasting help to a child except through his parents. This does not, however, rule out the possibility that we can know the child and his needs so well that we can effect a change in his behavior that subsequently results in a change in the parents' feelings toward the child. This assumes that the parent-child relationship is basically good. Caseworkers have developed special techniques for communicating with children to learn how their hopes and their desires may motivate them to get along better.[8] Caseworkers specializing in family social work have long known that treatment of one individual will affect others in the family.

You may say that certainly as caseworkers we would not fail to seek to individualize treatment. However, in practice we are under pressure to act and we don't always go through the necessary steps for individualizing. It is not enough to recognize mental subnormality. When we have specific knowledge regarding the cause and degree of mental subnormality in as far as it can be ascertained, we have only begun to evaluate treatability from the social point of view. We must take into consideration personal qualities, the family situation and relationships plus community resources, medical, educational and social. It requires a deliberate and persistent effort to practice according to our conviction that careful study, formulating a social diagnosis and planned treatment is the dynamic and closely related sequence of our casework activity.

I am sure that you also know that a caseworker may know many things about a child and family and their need for help and may be knowledgeable and orderly in the way she proceeds without finding the means of helping in such a way that an optimum solution is arrived at. The quality of the relationship between the parent and the caseworker is of course really of primary significance in determining how much help we can be. The parent who complained that a caseworker whom she met for the first time might at least have smiled may have been right when she assumed that there was something standing in the way of her receiving help. The parents' ability to form a partnership with a caseworker depends on many things that have to do with the parent, but the caseworker must also demonstrate himself to be receptive and responsive to the persons seeking help if the parent is to reveal himself and his problem.

We need to be concerned not only about the child but about the parents. Gertrude Binder states that, "Nothing is so crucial to a child's happiness as the happiness of his parents. If they have dealt with their problems and are getting satisfaction from their own lives they will be able to give him warmth and a real affection. With that as a shock absorber he will survive without injury experiences that would traumatize less fortunate youngsters."[9] Since retardation of the child is actually one of the problems of his parents, some relatively comfortable solution to the handling of his problems becomes crucial to the child's social development.

What approaches have been most helpful to parents? It may be well to remember that initially the parents denial of the child's retardation may (in spite of adequate and frank diagnosis) be necessary in the maintenance of their self-esteem. In view of this and in accordance with social work principles we find that it is important that the caseworker accept the family at the point they are in their acceptance of the mentally retarded child.[10] It seems that, to parents, insistence in the beginning that they should face the facts of retardation may mean that we want them to give up, and to face hopelessness. This is understandable to be resisted.

What makes for progress in the helping process? Again in accordance with social work method understanding of their disappointment and difficulties is the means whereby we establish the helping relationship which becomes the means of aiding both the parent and the child. We can continue overcoming resistance to facing and working on the very real problem of mental retardation, by giving interpretation and support in finding specific ways of understanding and helping the child. As the parent gains more satisfaction from accomplishing practical gains the retardation becomes less difficult to face. A confusion and anxiety felt about the child diminish as limits and capabilities for learning become clear. The parent gradually gains insight concerning the ways in which this child, a retarded child, is like normal children as well as concerning the manner in which he is handicapped. During this process of helping parents make this discovery about the potential of their child, social workers must of course make careful use of medical and psychological evaluations. Expecting too much can result in disappointment on the part of parents and damage to the self-esteem of the child.[11] On the other hand, over-protection may result in loss of motivation due to lack of achievement to a point where the child may need a great deal of encouragement and insistence to try over and over again to achieve what he has not achieved previously but has the ability to achieve.

We frequently find that community and family relationships are so badly disrupted by the time a child comes to our attention that two or more approaches are needed if efforts are not to be frustrated. For example, the physician may prescribe one of several types of medication now being used while the social worker helps the parents or others caring for the child to deal with their accumulated feelings of anger and frustration. Or special schools may be available to help retain the child while the social worker makes her contribution toward helping the parents provide a carryover of training at home. In some communities parents groups and others have established day care projects where trained personnel who understand the brain injured child can give some special training. This service to relieve the family of some of the strain of the child's care and gives them an opportunity to learn to be more successful with the child at home.

In conclusion may I say that it seems to me that we know a great deal about children in general that we may use in relation to the retarded child. Many of these things have to do with the needs of children and their parents. In addition, we need to know the special difficulties that stand in the way of these particular children and their parents when they seek to meet their needs. Although we can learn about these special difficulties from the parents and children themselves, we find that we also need to look to members of other professions in order to understand the meaning of these special difficulties in terms of affecting the integration of more of these children into the community. When we try to understand the attitude of a community we may need to look to the anthropologist. When we consider how much adjustment or change we can expect from the retarded child we find that there are many professions making contributions that are encouraging. These include the pediatritian, the neurologist, the psychologist, the psychiatrist, the sociologist, the epidemiologist, and many others. Research has been done and is being done that will make a great deal of difference in the potentials and opportunities for the retarded child. If we are to be effective in our area we must know about these and also think ourselves in terms of research possibilities. For inspiration let us not forget to look to our own philosophy, our own belief in the rights of human dignity and human self-determination. These are not to be held on high for all to see but rather to be practiced in relation to every human being.

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HELPING THE RETARDED CHILD DEVELOP HIS POTENTIALITIES THROUGH DEVELOPMENT AND USE OF LOCAL FACILITIES

Mildred Ziegler

In explaining this topic to me Miss Thomson said, "Tell us about what you do in your county." This would take a very short period of time if I had stopped to think about how I accomplished the few things that I have. This typewritten manuscript is my speech about my assigned topic. If I should read this to you, you and I would have an even duller time than we had thought possible. So I am going to lay this aside and talk to you about some of the happenings and how they were made to happen. Not only in my small county but in other counties throughout the state.

I wrote letters to 87 counties asking what they had done and received 25 replies with 17 counties admitting to having some special arrangement for caring for, entertaining, or teaching retarded people. I am a caseworker II in Kanabec County. My case load is everything except Old Age Assistance and there are four cases of that too.

The letters that I received had one common query. How do we develop local facilities? What techniques do we use? To me, the only discussion of this sort that is useful will try to answer their question.

How do we do it? The starting place is to learn to know your own community by getting acquainted with the teachers and school officials and by obtaining a count of the retarded children in your area. How? By studying the school census records, consulting with teachers, arranging for psychological testing, and interpreting testing to the parents, the teachers and to the students.

In doing all this we keep looking for the answer to the question, how many children are slow? How many lack particular learning skills? What does the school do now to help? What would the school like to do? What would the parents like done? How can they help?

If we know these answers we next tell the local organizations about the facts. We write about it in our newspapers, hold workshops in our welfare offices for key people and hope to get the backing of a local group to encourage the school and community to develop the proper resources.

We can do all these things if we remember this, if we talk plain dollars and cents, it is cheaper to hold special classes in our schools for children with I.Q.'s under 50 than it is to support these children the rest of their lives. Certainly the I.Q. should be at least 50 for public school classes. Yes, training in private groups on a nursery school level to learn to meet every day living would be very, very helpful to children under 50 who either cannot or need not be sent away to school.

As we have been considering these methods of encouraging the building of resources in our community for special things, namely help for the retarded child, we began to see that the caseworker with her special training has a unique place and obligation to the community. She knows how to do casework with the retarded person and his family, but she also knows how to organize community thinking to accomplish a definite end. It is at this point that we guess workers often fall short. When we try this work, we are amazed at the results. We forget that we are the one person in the community that knows almost everybody, that knows facts no one else knows, except the family of the retarded child, and possibly the teachers. We forget that everyday work provides a source for forming public opinion. It is true that parents groups help us a great deal in doing this but except in very unusual circumstances it is necessary for the caseworker to be the initiating tool for changing public opinion about such a thing as special classes or care for the retarded. We not only need to help the community to understand this problem but we also are instrumental in obtaining the cooperation of our Welfare Boards without whom we could do nothing. Maybe we were putting the cart in front of the horse when we told you about the steps in the community before we told you that we had to have the cooperation of our Welfare Boards in order to successfully accomplish any of the above things. Most Welfare Boards are genuinely concerned about the retarded child. They are also concerned about the cost for the future of these children so it isn't difficult to interest them in your project.

What has been accomplished in my county by these techniques? I have the support of my Welfare Board in doing whatever I can to protect, help, and educate the retarded child. In just this past month after over 15 years of trying here and discussing there, I have found parents of a retarded child who are capable of and interested in starting a Parents Group. Mr. and Mrs. L., the parents, have received from me the address of the Minnesota Association for Retarded Children. We are on our way toward the best means that I know for bettering community resources - a parents group of our own.

I am trying to interest the local Superintendent of Schools in special classes. His reply is, "How can we think of classes for slow students when we lack six classrooms for average students and already the tax payers are complaining about school taxes?" I say to him that the whole thing will work itself out, that if people are going to continue to have an increased birth rate they are going to learn to pay for additional education costs and then I repeat the statement again about the cost of the community of supporting one retarded person for his lifetime as compared to the cost of a few years of special class training. A special teacher not only helps the slow students but frees the other teachers for work with the average student. Learning to read and to write and to speak will give even a slow person a chance at happiness and opportunities.

What have I done all these years to help retarded persons in our community? I have explained retarded people to the community. I have counselled with the parents and teachers. The agency has paid for many psychological tests. We have succeeded in fitting a number of retarded persons into community life. Financial guardianship and friendly, continuous, always available council permitted one widow with an I.Q. of 42 to raise her two girls. An excellent boarding home for four difficult retarded children has been developed. How? By evaluating a widow's potential for loving any helpless child and by offering her reliable guidance and moral support in the venture. By helping her to know the retarded children and to learn how to care for them. Last fall a neighbor asked to have the boarding home closed because the children were distressing to her and she could not stand to hear them cry. The Welfare Board stood with us in encouraging the boarding mother to continue her work. I found in talking with people of the community that the children were not offensive. This neighbor, I learned, had had a nervous breakdown and had been spending all her time watching these hyperactive, sometimes epileptic, children. We explained to the husband. We promised that if another more suitable location could be found, our boarding mother would like to move. I realized that I had not explained the boarding home enough to the community. Therefore, at Christmas time the Girl Scouts were interested in providing a basket of fruit, the local woman's club bought nursery rhyme phonograph records for the children. In each instance the limitations of the children and the care given them was explained. This increased the community's awareness of the problem of retardation and gave the boarding mother the feeling that the community valued her work.

I am amazed at some of the developments in other counties. Ramsey and Hennepin counties are ahead of us all in special classes, recreational and vocational opportunities for the children.

Albert Lea has two opportunity rooms and a nursery class. The nursery class prepares children for the opportunity room. Transportation expenses to it are often met privately. There is a class for older persons for one day a week for handiwork and reading.

In Crookston, two housewives do private tutoring of retarded children. In Windom there is a Beta class for children of 50 I.Q. and below. Rochester has a particularly active parents group. There is a West Central Association for Retarded Children that is active but so new that the results are not yet available. In Wheaton the local Mrs. Jaycees are interested in retarded children.

Austin amazes me with its report of a Parents and Friends group incorporated with the Community Chest. They maintain a school for retarded children with a full-time teacher. There are special classes in Sunday School. The city recreational program gives slow children a place. The Cub and Boy Scouts have troops for them. Summer camps are valuable. The parents group holds workshops. Austin has Dr. Gamelin as head of psychological service. The public school has a full-time professional social worker. Mr. Mickelson, who appears later on the program, will tell you more.

Stillwater has a special class and a boarding home for 3 retarded children. Redwood reports PTA interest, an active parents group and one going class for I.Q. less than 50 and a new one starting. Dakota county gives major credit to parents groups. In Anoka the Jaycees are thinking about a benefit wrestling match to help. There is a local special class and a beginning parents group. There is a private boarding home. Fergus Falls in Ottertail started, 10 years ago to improve or develop resources. There is an underpriviliged children's committee in the Kiwanis Club. The Kiwanis Club started a class and the local school board finally took it over. The school continues two days during the summer. Special trips were taken with transportation provided by the Kiwanis, supervision by the parents and picnic lunches for all.

Thief River Falls has parents groups with special classes for the children under 50 I.Q. but they find that it would be more useful in the public school, if the children were over 50 I.Q. Parents groups provide recreation during the summer with supervised story telling, games and swimming.

Some questions arose from these letters which might be taken into consideration during our discussion. Could there be itinerant teachers in sparsely settled areas? What do very small counties do about special classes? Should public schools have classes for children under 50 I.Q., or instruct only those over 50 I.Q.?

I end up by saying, oh, for an active parents group, but in the meantime explain, explain, explain, and look for every opportunity to develop resources. Yes, we can do all these things even in spite of our case loads.

HELPING THE RETARDED CHILD DEVELOP HIS POTENTIALITIES THROUGH PLACEMENT IN AN INSTITUTION

C. M. Henderson

This title has in it two key thoughts -- "The Retarded Child" and "Institution." Actually, one cannot discuss retarded children in general, and it is questionable whether institutions can be discussed as a single concept. There is no such thing, in my opinion, as a "retarded child." We would have to discuss a particular retarded child, or some particular group or type of retarded children. The term, "retarded child" is much too general to discuss in a paper of this kind.

It will be necessary, therefore, for me to restrict my comments today to the "mildly mentally retarded boys and girls" -and- primarily to the "Owatonna State School." I hope, however, that much of what I may have to say may be applicable to retarded children in general and to institutions for the retarded in general.

Before entering upon the contributions to self-development provided to the retarded by institutions, I would like to review with you a concept that is widely held by many professionals and by non-professionals. This concept states that, if a mildly retarded individual in a community is having emotional problems, or is delinquent or pre-delinquent, his problems stem from the fact that he cannot compete adequately. It further contends that, if that individual can be institutionalized, he can -- and almost always, will -- lose most of his a-typical behavior on being placed with his "own kind." At Owatonna, this has not proven to be true. By-and-large, children who are mentally retarded and who have problems of adjustment in the community, also have problems of adjustment in the institution. To be sure, there are some rare cases, however, who do seem to adjust in an institution for the mentally retarded who do not adjust in the community.

I think we would have to contend that the general principle of being with one's own kind does not make for better adjustment with the retarded than it does with normal people. Normal children, along with high-grade retarded, are delinquent because they have adapted themselves to a pattern of life that the community is capable of helping them to produce. The very fact that a child has become delinquent may mean that he is capable of learning delinquency patterns just as are the so-called normal children who also become delinquent or emotionally upset.

Secondly, the high-grade retarded person may also become delinquent, or a serious problem in the community, because of his own inner problems. He may be disturbed, not primarily because he is retarded - but, for the same reason that many normal children become a problem, whatever that reason may be.

The position that retarded children become community problems for entirely different reasons than many normal children become problems is a position that, in my opinion, is untenable. It has not been the experience at Owatonna that children who are retarded present no problems to an institutional community merely because they are with their own kind.

Before we go into the contributions that an institution can, and does, make to a retarded individual in helping him to develop whatever potential he may have, it is essential, I believe, to understand that problems of behavior are not always due to the fact that the retarded cannot compete and that relieving him of the necessity to compete solves all his problems.

Among the contributions that an institution can provide to retarded children in helping them attain their maximum effectiveness in the community, are:

1. An environment that is more-or-less consistent in all, or most, of its areas. The normal community is primarily designed for people of normal intelligence, just as it is primarily designed for right-handed people who are somewhere between five-feet and six-feet tall. People who are left-handed run into a good many problems merely because right-handed people are in the majority. Very tall people -- and people who are abnromally short -- run into many problems because furniture, houses, etc., are designed and manufactured for normal people. The retarded have problems also, because most homes and all modern communities are designed for people of normal intelligence. Schools, Scout Organizations, Churches, and almost all other community organizations are designed for normal people. For example, the means by which people in a community communicate, either by word-of-mouth or through writing, is most often such that it cannot be fully comprehended by a retarded individual. Our society is so constructed that there are many complicated blanks and reports that need to be made out, such as the Income Tax Report, that a retarded individual finds himself competely lost in trying to comply with the demands of the community.

The retarded individual finds it necessary to continually make adjustments, and he may not have the where-with-all to make adjustments. The conversational vocabulary is not one that he can always understand. The rigid standards of social graces and the mode of dress are not flexible enough so that he can understand them and meet their standards. He may find himself in a continual state of confusion and inconsistency. He is forced to function in a world that was not made to fit his type of personality and one that he may not be able to understand. I would like to point out, however, that though the above point ;f view is one that is generally true, there are cases of mentally retarded individuals who can, and do, make adjustments to community demands upon them. This position is not a contradiction of the premise stated above. The delinquent defective by-and-large is one who can, and does, accept the standards of a phase of the community life. The very fact that he can become delinquent is, in a sense, proof that he possesses some ability to accept and perform according to certain community standards.

Institutions for retarded are designed for retarded and are more-or-less consistent in all of its areas. In the community, the retarded individual may find understanding and reasonable sympathy as an individual in his home and in certain groups of people. If he is in a special class, he may feel very much at home while he is in that class. But on the playground or on the bus, or in the store, he may become the butt of jokes and ridicule. He is never quite sure when he meets a person for the first time, or when he enters a store, whether he is going to be accepted or rejected. I had a colored soldier tell me once that he would rather live in the South than in the North, because in the South he knew where, and under what circumstances, he would be accepted. On the contrary, this person was never quite sure when he entered a barber shop or a restaurant in the North that he would be treated on equal terms with white people. He recognized certain subtle rejections that were confusing to him.

One of the primary contributions of institutions to the self-development of retarded children is an environment that is more-or-less consistent. He has a chance to learn a degree of consistency.

This does not mean that the retardate does not have adjustments to make in an institution and that the environment is always completely suitable to his personality. It merely means that, whatever it may be, it is consistent so that he can adjust to it with some degree of confidence. The colored soldier mentioned above, was not necessarily happy in the South, but he did know its rules and he could, with confidence, make whatever adjustments that were necessary. He, according to his own statement, preferred a bad situation that was consistent, to one that was somewhat better but inconsistent.

2. The second contribution that an institution for the retarded can make to the development of a retarded individual's potential is to provide him with the possibility of developing an attitude of (we-ness) a sense of belonging. This is, in a sense, a corollary to the first point made. He can perhaps, for the first time in his life, possess a real sense of belonging. This sense of belonging may exist insofar as the retarded are concerned on a family level. But what I am talking about is a sense of belonging in a larger community consisting of people other than members of the family. This sense of belonging is not a family tie. The institution is a world of people and things outside his family, to which he can have a real feeling that he will be accepted if he makes the proper relations. Not all retarded individuals in an institution have this sense of belonging, but the institution provides an environment that will accept the retardate if he can, and does, make the effort to become accepted. It will indeed attempt to teach him how to become a part of this institutional community on a reciprocal basis. In this environment, he can develop techniques and strengths in the art of accepting and being accepted by the world about him.

3. In this new institutional community, the struggle for equal recognition with others is reduced to a minimum. Every child with a sibling near his age is in competition for his fair share of love and affection, food, toys, entertainment, attention, the family automobile, etc. Parents know that with non-parental personnel such as baby sitters, etc., this problem is greatly reduced because the baby sitter, or the person who is not a parent or a true parent substitute, does not possess the love and affection for which the child is competing and therefore, there is greater harmony when a child is being cared for by people other than the parent. Siblings seldom develop a serious spirit of competition over the attention that is paid to them by a Public School teacher, for example. Children who are quick to notice a favor given to a sibling by the parent seldom feel strongly if the same action is taken by an outsider.

The institutional housemother does not become a parent substitute in a real emotional sense and so the competition for love and affection, toys, etc., does not exist in the same sense that it exists in the parent-sibling relationship. The child can then learn to compete on a fair, though not on an entirely unemotional way with peers. Food, clothing, entertainment, treats, etc., are all provided on a more-or-less equal and unemotional basis to all. In the case of the retarded child who has normal siblings, this is a service that the institution can offer in helping him develop his potential to the fullest.

It is my opinion that the individual is influenced by his sibling relation as much as by any one thing in his environment. In an institution, he is relieved of this competition which, in many cases, is much too great for him, and he is given a chance to develop unemotional relationship that approaches the normal to some degree.

4. The institution is, to a more-or-less degree, separated from the community. There are some bad features about this. At the same time, it offers some positive advantages.

One of the reasons retarded children have problems in the community is because they appear to be older than their abilities. A twelve-year-old may, for example, have a mental age of six. He is allowed to go to town or to the store alone and when he acts like the six-year-old that he is, he finds himself taking things or acting in a way that is normal for his six years, but unacceptable to a twelve-year-old.

A sixteen-year-old with the awakened sex impulses of adolescence, finds that his eight-or-nine-year mental age does not give him adequate controls to meet the temptations that confront him.

Placement in an institution removes at least the external part of the temptation and provides external controls essential for helping him handle these natural, but troublesome temptations.

5. In order to help the retarded develop his potentialities through placement in an institution, schooling within the limits of his ability are provided. At Owatonna, the largest item in the budget provides the teaching staff of a principal, a librarian, a shop instructor, and 21 teachers -- making a total of twenty-four (24) on the teaching staff. It is our firm belief that the formal school program should have as its sole objective -- that of helping children develop their potentials.

No one, to my knowledge, has designed a school program and curriculum for retarded that is universally useable. Few good curriculums have been constructed. None have been devised that can be used in any, or all schools. The field is so specialized that in almost all instances the curriculum is designed to train particular children to do particular things. The training is so geared to local situations that it can hardly be adopted and used by schools serving another area.

At Owatonna, we do not have, as yet, a written curriculum. We have done some preliminary work toward developing one, but at the present time it cannot in any sense of the word be called a curriculum.

A curriculum, as we see it, must not be a school-centered curriculum, but it should be child-centered. It should take into account, not only what occurs in the classroom, but must concern itself with the activities of the children in every phase of life in the institution.

In this respect, the institution can, and does make constructive contributions. It can design its program to coordinate the teaching program in the school with the living program in the cottage -- with the on-the-job-training in the many areas where the children work. We will be satisfied only if our curriculum makes each area of the child's life a teaching situation that is coordinated with every other area of his or her institutional life contributing to the specific needs of individual children.

Health is never taught only in the classroom. It is also taught in the home, at work, etc. In an institution, the condition is no different. The child gets health instruction in the cottage where he bathes and sleeps and washes his teeth; he gets important instruction in the dining room where he eats, as well as on the job where he works.

In the community, it is rare that the teaching a child gets in the school is consistent with what it is in the home. It is also true that institution life is seldom consistent. But, ideally, it can be and should be. And, at Owatonna, it shall be.

Coordinating the efforts of several departments takes a great deal of administrative planning and leadership. It takes time for a variety of personalities to blend themselves into a common cause, but we feel that the necessary effort to bring about this blending is energy well expended.

This is a contribution that institutionalization should be able to provide retarded children, that is seldom, if ever provided by any community program. This is doubly true where the child lives in a home that is extrememly inadequate. Institutionalization, then, can be particularly effective where the home is unable to be consistent with its training program. Inconsistency between the school and the home is not always where the home is socially sub-standard. Many homes cannot seem to provide a relaxed and permissive type of homelife, which may be provided by the school.

It appears to me that, where the elements of the community environment are grossly inconsistent and conflicting, the institution can, and does, offer what is necessary for the child to be able to develop his potential.

THE RESPONSIBILITY OF THE MEDICAL PROFESSION FOR THE MENTALLY RETARDED AND HIS PARENTS

Robert Bergan

Miss Thomson, Doctor Jensen, and friends, I feel quite honored to have been asked to take part in the discussion this evening at this institute for the study and consideration of the problem of the mentally retarded. Doctor Jensen, I have been here all day listening to the earlier speakers on this program, and it has occurred to me that I was sitting amongst a group of splendid people, all very dedicated folks. I have always felt that the medical profession as a group doesn't really appreciate the good work that social workers, public health nurses, and other workers in public agencies do to assist us in so many ways in our work as physicians. I feel that the medical profession as a group has also lagged in its interest in this field under consideration by this institute. Doctor Jensen has mentioned the institute on mental deficiency which was held here one year ago and which was attended only by physicians. I am glad to say that I was one of those invited. I enjoyed the program a great deal.

This whole problem of the mentally retarded among our population is a big one. It involves a great number of people. It has been said that 1 - 2 per cent of our population would fall in a group below an I.Q. of 65 or 70. We, as Americans number about 170 million people. It is easy to see that this number involves a great number of Americans, most of whom are not in institutions.

The physician should really be considered as part of this team which is working for the health and advancement of the mentally retarded. He, as a physician, has a unique place, being, very likely, the first person sought by parents who are becoming aware of the fact that their child might be mentally retarded. The physician serves the child really through the agency of his parents and he must use his medical knowledge to diagnose and explain as best he can the problem from the medical view in any case of mental retardation. The physician's responsibility does not stop with making a diagnosis or even with institutionalizing, if this is advised, but should always remain part of the team which is concerned about this particular child or adult who is so afflicated. The physician's part or help in this work is (1) to make the proper diagnosis, (2) to institute such treatment as might be indicated, although in most cases medical treatment offers so little, and (3) to do his part, although small, in the overall plans for the educational training or custodial care of this retarded child or adult.

First, let us consider the etiology of mental retardation. It has been said that at least half of mentally retarded people cannot be specifically classified or have no significant medical condition or illness to account for their mental retardation. These folks are simply classified as "Mental Retardation, undifferentiated," and their handicap is not associated with any other significant condition. There are a few hereditary conditions, however, in which germ plasm defects or constitutional inadequacies afflict the person in many ways, one of which may be mental retardation. Such conditions are mongolism, Schilder's disease, familial idiocies, certain congenital anomalies, etc. Then, too there are environmental conditions in which mental retardation is a part. These conditions may be pre-natal, or post-natal in classification; such things as maternal infections, Rh factor, cretinism, birth injuries, anoxia of the newborn, convulsions after birth, whooping cough, etc., all may result in mental retardation in one degree or the other. Occasionally, the cerebral palsied child has a mental retardation, although this is not always the case. In such cases, it has been the common thought to blame the obstetrician for an error in judgment of obstetrical care of the mother and child. Under present levels of medical practice, it is doubtful whether cerebral palsy results from physicians' errors to any degree.

Once the physician has established the diagnosis of mental retardation and has associated it with some other medical illness or diagnosis, if there be an exact diagnosis, he may to some extent forecast to the parents and family what can be expected of the child. However, he must be sure that the child really has a mental retardation, since hearing loss, speech defects, thyroid deficiencies, infantile autism, and other conditions may lead him astray in making an opinion as to mental retardation. Occasionally, the child is brought up in a very unstimulating environment and backward conditions, but when given a chance it becomes apparent he is not really retarded at all, not having been given the opportunities other children have had. Then too, there is always the possibility that an intelligence test may be in error for one reason or another. I doubt that this holds true in our state now with the psychologists that we have to help us, but actually no psychological test is any more accurate than the ability of the person administering the test. So, the physician must be very careful not to be mislead to make a diagnosis of mental retardation until he is very sure. He should do a careful history and physical and conduct a careful interview with both parents. It is his duty to refer both the patient and his parents to adequate psychometric examination centers for psychological testing to clarify his diagnosis.

At this point, we should make some comments as a matter of interest to distinguish the so-called brain-injured child from mental retardation of an undifferentiated type. A brain-injured child is one whose retardation is due to injury at birth, jaundice due to the Rh incompatibility known as erythroblastosis, anoxia at birth, or severe infections in infancy in which the brain is actually damaged in some way or another. These children are quite variable in their activity, consequently will be quite variable in their response to testing in psychometric examinations. They have their ups and downs, as we say. They are quite unpredictable. They tend to be very overactive and somewhat hard to manage. They have a very short attention span, very often react to situations with a "catastrophic" reaction. When met with a decision or some alarming experience, they tend to go to pieces over things which we would consider rather minor. In their school work, they have the most difficulty with the very objective studies, especially arithmetic.

There is very little to be said about the medical treatment of mental retardation. The primary medical illness should be treated, for instance, cretinism or other related medical illness in which mental retardation is a part. The drug treatment is of little help in the treatment of mental retardation. Reserpine, thorazine, glutamic acids, and amphetamines are of some help, but results are not striking.

The physician should do his part in directing the mentally retarded person and his parents to proper agencies such as you folks who are particularly interested in the education, training, development, and custodial care of the mentally retarded. I think at this point one should compliment the new parent groups of the mentally retarded for their excellent work and the many ways in which they help, not only themselves, but the general public in handling this problem.

In summary, it is the physician's responsibility to inform carefully the parents of the mentally retarded child as completely as he can, to answer all their questions concerning their problem. He should use his medical knowledge in his thoroughness to define clearly the total problem and outlook in every case. He should be sure to make an exact diagnosis or use such help as he needs to make this exact diagnosis. He should discuss the cause thoroughly with the parents and treat whatever medical illness the condition is associated with. He should remain interested in the child and help in every way that he can to make plans to educate, train, and take care of the child. He should always remain a constant source of information and counsel to alleviate parents' anxieties and always lend his sympathy and understanding to the mentally retarded person and his family.

WHAT IS SUPERVISION

Frances M. Coakley

Mr. Chairman, members of the Institute on Mental Deficiency, I want you to know that I am so very happy to meet with so many of you again and to meet with all of you who are interested in work with the mentally deficient. I realize that my topic, "What is Supervision?" is so large that I shall only be able to touch the highlights during the talk today. Since I have returned to working directly with social workers in a county agency, I feel that it is necessary for me, first to comment on one misconception that I find current among many professional persons to the effect that retarded children and adults have just been discovered, that little is known about them, and that scientific persons have not been interested in them. Nothing could be further from the historical facts. In the early 1800's in France, Itard and Seguin did a tremendous amount of work in seeking methods of educating mentally deficient children to meet <u>social</u> life. Their work in training made a real contribution to our knowledge of work with normal children because many of the devices they developed had wide application to children of all types and were much used in schools during the next century. A hundred years later, Binet, who called the attention of the modern world to the wide differences between children by developing a series of tests that apply to all children, was actually seeking a method for separating retarded from normal children in order to reduce the injustices that held in placing children in institutions. The joint problem of diagnosing retardation and of educating retarded children has been with us for a century and a half. Many thousands of persons in various countries have devoted large portions of their lives to the study and training of retarded children. There have been many scientific articles about them. In many respects mental defect is one of the areas about which we know most rather than one about which we know little. It is true that very recently there has been a great impetus towards the development of more community programs for the mentally retarded and along with that an upsweep in community and public interest in the retarded. I have felt that it was necessary to make these statements regarding a bit of the historical background in the field of mental deficiency since I have found so many professional workers who have not bothered to check with sources in the field since they were laboring under the misconception that little had been done or written in this area.

In discussing supervision the definition as written by Mildred Thomson is that "Supervision is the service given a ward and his family for the purpose of helping him to adjust adequately in the environment in which he is living. Or, if this is impossible, to change his environment. It implies understanding of the ward and his family, both as to personality and ability, as well as the emotional attitudes involved. It also implies knowledge of facilities available and a readiness and imagination to find and use facilities that might be made available. From our present manual for the welfare boards we find that the main functions of guardianship are three: To set standards of proper behavior for the ward; to protect him from exploitation and neglect; and to offer resources which would not otherwise be available to him. The particular emphasis will depend upon the individual needs of each ward; however, all work must be based upon adequate diagnosis and a realistic acceptance of the ward's limitations and of the fact that he is under guardianship."

The legal basis on which we and the County Welfare Boards are operating is based on Section 525.762, Sub-division 2 which states: "Upon commitment of a mentally deficient or epileptic patient, the director may place him in an appropriate home, hospital, or institution or exercise general supervision over him anywhere in the state outside of any institution through any Child Welfare Board or other appropriate agency thereto authorized by the director."

In considering supervision for any handicapped individual my thinking goes back to the goal set at the 1930 White House conference on child health and protection which set the goal for the handicapped child with a Bill of Rights which stated:

THE HANDICAPPED CHILD HAS A RIGHT

1. To as vigorous a body as human skill can give him.
2. To an education so adapted to his handicap that he can be economically independent and have a chance for the fullest life of which he is capable.
3. To be brought up and educated by those who understand the nature of the burden he has to bear and who consider it a privilege to help him bear it.
4. To grow up in a world which does not set him apart, which looks at him, not with scorn or pity or ridicule-----but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibility.
5. To a life on which his handicap casts no shadow but which is full day by day with those things which make it worthwhile, with comradeship, love, work, play, laughter and tears-----a life in which these things may continue in increasing growth, richness, release of energies, joy and achievement.

In attempting to carry out these goals it might be well for us to analyze what we mean by mental deficiency and also consider whether the mentally deficient are like or different from the normal. The definition of mental deficiency which I have generally accepted is that of Dr. Edgar A. Doll who states, "Mental deficiency is a state of social incompetence obtaining at maturity, or likely to obtain at maturity, resulting from developmental arrest of intelligence because of constitutional (hereditary or acquired) origin; the condition is essentially incurable through treatment and unremedial through training except as treatment and training instill habits which superficially compensate for the limitations of the person so affected while under favorable circumstances and for more or less limited periods of time." This definition assumes that interest in the mentally deficient person derives from his inherent ability to manage his own affairs successfully and to live effectively without need of supervision or assistance. It further assumes that such interest is directed toward suitable measures of social protection, help and control without which the person so affected would sooner or later become a burden on his family or a menace to society. Dr. Doll writing about "Understanding the Handicapped Child" brings to our attention that if one would visit a group of mentally deficient individuals one would note that they can see, they can hear, they can run and walk, they can jump, they can talk, they can swim, they may play football, basketball and baseball; they do a great many normal things. He points out that it is a question of degree or the emphasis of direction of their handicap. When one has defined the degree and the nature of the handicap, one still has a person to deal with. He points out that we need to get beyond the handicapped and see what is left. We need to ask what needs of the handicap distinguish them from other individuals and generally we will find that there are few differences except in degree. In other words, the handicapped or the mentally deficient person needs the same thing the normal person does but needs more of those things.

Richard G. Guilford, formerly of our University of Minnesota School of Social Work, noted that the first thing we observe in analyzing the mental deficient person is that his personality needs are the same as those of anyone else. He needs to be financially and socially secure. If he is not he may react with delinquent or other kinds of behavior which society will not tolerate. So in starting with our work with the mental deficient we must ask ourselves what does this person need to get along with a reasonable degree of social success? What are his love and affectional needs and are they reasonably satisfied by his family or substitute family group? Does he have a place in society where he can count, such as work commensurate with skills attainable or reasonable acceptance and participation in community life? If and to the degree that we can accept this as a basic clue to the personality needs of the mentally deficient person we can understand why some of our wards develop such difficult personalities and others such acceptable personalities in the face of equal I.Q.'s and even very low I.Q.'s. Frequently we find that troubles and behavior problems are usually not due to low intelligence but rather to wrong methods of handling.

A rather interesting study of personal characteristics of the mentally deficient and of normal people was done by William Sloan and Allen Raskin. In the January, 1952 American Journal of Mental Deficiency in their article "A Study of Certain Concepts in High Grade Mental Defectives" Sloan and Raskin administered a series of 12 questions to sample fears, wishes, moral attitudes, practicality, concepts of companionship, concepts of greatness, levels of aspiration, positive and negative identifications, and entertainment levels to 91 male and 30 female adult mental defectives and compared this with a group of normal children composed of 22 boys and 25 girls of similar mental age. The normal children had a mean chronological age and mental age of 8 years and 3 months. This study showed that the adult defectives appeared to be more mature than the normal children in their ego ideal identifications, levels of aspiration with respect to vocational choice, "fears", wishes, and practicality. No differences appeared in recreational choice, negative identification, and moral attitudes. The authors stated that "These findings point up the need for considering factors other than intelligence per se in evaluating the maturational level of the adult defective. We see that the adult defective has acquired some concepts and attitudes at a higher maturational level than that of a "normal" child of similar mental age. Hence we can expect the adult defective to make a better social adjustment than could be expected from a "normal" child of the same mental age. Experience, apparently, is a considerable factor in adjustment and is not reflected in the I.Q. alone.

Up to this point I have been talking primarily about the ways in which the mentally deficient individual is like most of us. We recognize, however, that there are many ways in which the mentally deficient individual differs from the normal. It is important and basic that the social worker understand the differences which we will find in varying degrees in the mentally deficient. We may find lack of power of self-criticism, limited power of association, an inability to keep unusual instructions in mind, a failure to detect errors and absurdities and statement in a common-place situation, a tendency to have concrete abilities rather than abstract, possession of limited powers of reasoning, visualization, and similar mental traits, defective attention, defective memory and recall, defective range and span of interest, defective reasoning, sometimes a lack of ambition and drive, and susceptibility to antagonism and stubbornness when asked to reason or rationalize his behavior in society. We would hope that our understanding of the mentally deficient personality would lead us to a feeling of acceptance and understanding without which we cannot work successfully. As social workers we must continually ask ourselves as we go about our individual jobs of supervising the mentally deficient for the community how we individually feel toward this group with whom we are specially focusing our social skills.

The problems of the mentally deficient generally are approached from a sociological orientation in terms of general problems faced by this group and social planning designed to help the individual make maximum use of his limited assets. Undoubtedly these latter factors are of the utmost importance and should be clearly understood by a case worker when working with the mentally deficient. Nevertheless, it is not uncommon for the case worker, in his desire to be of help, and because of his understanding of the problem shared in common by mental defectives, to be tempted to take over the client's problem and attempt to solve it with only a minimal degree of participation by the latter. The rationale for this approach is usually cast in terms of the individual of defective intelligence being unable to meet the intellectual demands of problem solving within the frame of reference of the conventional case work process. This premise may have some merit in those cases where the intellectual level falls below the moron range. Within the moron group the validity of this premise breaks down.

In the past there has been some feeling that psychotherapy and intensive case work with the mentally deficient was not possible. This concept is beginning to break down and in many parts of the country it is inherent in the case work process that the patient can be helped to participate in the sort of practical thinking that is essential to his planning for the future.

Winnifred R. Wardell in her article on "Case Work with the Mentally Deficient" in the American Journal of Mental Deficiency of April, 1950, also emphasizes that, "Mental defectives differ in personality as well as ability. Their attitudes vary as do their interests. It takes real skill on the part of the social worker to work with such people. Some morons need more direction and help than others. Help must be given at no faster rate than the person can use it, and frequently we over-estimate or under-estimate the person's capacity for help."

"By some, it is felt that the passive worker is not too successful in working with the mentally deficient. Passiveness on the part of the worker often interferes and further retards the ability of the client to function. A person in a state of anxiety needs help. A frustrated mental defective also needs help, and frequently immediate action or help will sustain him for years. Active guidance and participation on the part of the worker frequently is far more efficacious with a mentally deficient person than the do-nothing, passive technique."

In our concept of supervision for the mentally deficient in Minnesota, we believe that we have the full responsibility of utilizing all resources within the community and doing everything possible to help the individual make satisfactory adjustment. In general we consider that we have twelve main areas of supervision. They are as follows:

1. Living arrangements
2. Health
3. Training and Education
4. Vocational guidance
5. Employment
6. Budgeting
7. Personal relationships
8. Recreation
9. Religion
10. Marital problems and child care
11. Provisions of legal services where needed and protection with involvement with the law
12. Provision of financial assistance when necessary.

Out of my own experience I find much concern about the concept of accepting people as they are and of faith in people. I find that it is so difficult for many of us to understand how much strength and how many abilities exist within the mentally deficient. I know that work with the mentally deficient is time-consuming and that it is strenuous, but at the same time the challenge of the difficult is most rewarding. I have found so much help in the Overstreet's new book, "The Mind Goes Forth: The Drama of Understanding". They start out in their first chapter describing the process of understanding and it has seemed to me that this can very well be applied to our work with the mentally deficient. For instance, they say, "There are many directions the human mind can take; but the most exacting--and rewarding--is towards another human being. There is hazard in taking this direction, as there is hazard, for that matter, in all use of our human powers. Living itself has to be counted as an act of faith; and there is a faith appropriate to every adventure life offers."

"To be skilled in our approach to other minds does justice to them and to ourselves. It lets us pay respect to what is subtle and what is unique in each human being. Man must live with man. He does well to make generous rules for his fellowman; and he may rightly hope that generous room will be made for him." The Overstreets also write about space-making institutions and the liberating mind. I cannot wonder if perhaps we are not in an era of space-making institutions and a liberation of our minds and that the very meeting such as today indicates the restlessness with our present social organizations and our strong desire to quickly proceed towards greater service and the development of additional facilities and resources. I cannot help in thinking about space-making institutions that would include such organizations as our association for retarded children.

Rufus Jones in his Inter-dependent Reader has noted, "Strange stirrings of hope and expectation are moving across the world." It is possible that we may be on the fringe of a new and marvelous epoch. It is one of the evidences of man's intrinsic greatness that it is just then, when he seems to be at the end of his human resources, that he rises above himself and does what he could not do."

PREPARATION FOR PLACEMENT FROM OWATONNA STATE SCHOOL

Francis Stevens

In order to discuss the assigned topic, it is necessary to first define some of the terminology that is to be used. One must understand that Owatonna State School is not an institution in the same sense that other state facilities for the mentally retarded are.

One must further understand that preparation for placement must be defined in two broad areas. The first area would be, "Who has responsibility for placement?" and the second area would be, "When does preparation for placement begin?" Anything else that I can say about preparation for placement would naturally come out of these two headings.

"Who has responsibility for preparation for placement of a child from Owatonna State School?" To refer back to an earlier statement, Owatonna State School is a <u>School</u>. Children normally come to Owatonna somewhere around age 8 or a little older, and they normally leave Owatonna somewhere around age 21. If our in-take processes have been adequate and we have done the job that we would like to do at in-take, the child leaving Owatonna leaves Owatonna to return to the community. He will have had a program of education and training which will hopefully have equipped him to take his place in the community and be self-supporting or partially self-supporting.

With that thought in mind, we can then talk about responsibility for placement in the community. Responsibility belongs in three areas, (1) the parent (2) the county social worker (3) the state school staff. The responsibility of the parent starts prior to the time the child enters the school and remains with the parent indefinitely. The interested parent maintains contact with the child, plans with the child for the day the child will return to the community.

The county social worker has many contacts with the child prior to the time the child comes to Owatonna and hopefully will maintain these contacts with the child all of the time the child is at Owatonna. She should assist in making plans for the child at the time the child leaves Owatonna. In order to be able to perform this function, of necessity, the county social worker shoudl have continuing contacts with the child and should assist in preparation for placement. The county social worker should see the child at least once a year at school, preferably oftener.

School Staff responsibility for placement is probably the broadest, and in order to talk about School Staff responsibility we probably should go back to the second broad topic, "When do we begin preparation for placement?" Preparation for placement began prior to the admission at Owatonna but after acceptance by the Owatonna State School of the child. It began with an explanation to the child of where the child was going, and why.

It began with an explanation to the child and the parents of the function of the Owatonna State School, that of education and training. It is a continuing process and here is where the State School staff meets its responsibility. The responsibility is not met in the same degree with every child and each child may not be exposed to each and every aspect of preparation.

Vacations from Owatonna State School play an extremely important part in preparation for return to the community. They provide an experience for the child for part of the year in living in the community he or she will return to. It is extremely difficult for the child who has been 10 years without a vacation, without an opportunity to live in a home to know the experiences of going to church, going downtown to the movies, buying an ice cream cone, to make the transition from the state school to the community. There is the risk of becoming institutionalized when one lives in an institutional setting. We do not want complete institutionalization of the children at Owatonna, as it makes for them real difficulties in returning to the community. Another part of preparation is visits, both to the school by parents and social workers, and to the community by the child. The Easter vacation or visit is valuable to some of the children in maintaining their contacts in the community and makes the transition to community living easier for them. It is used by the staff at Owatonna as a means of preparation for placement, it is a short but essential experience in the community. Once a year the staff at Owatonna reviews every child's progress with one point of view, and that is to determine whether a child should or should not have a summer vacation. When the staff recommends a vacation it is with the thought in mind that the child needs the opportunity to get away from the school, needs the opportunity to have experiences in living in the community in order to make for a better adjustment later on.

Our school program falls in three categories: (1) Academic-half-day (2) a section which could be called crafts or vocational training, shop-type activities-half-day (3) and a job training program which is given to the older children. A word of caution should be used here to point out that we do not turn out machinists, electricians, plumbers or carpenters. We teach work habits, we turn out a finished product that hopefully will be able to be a good carpenter's helper, a good plumber's helper, but he will not be the craftsman. Our academic program is being overhauled, we are trying to make it more meaningful to the children in terms of their life in the community. We are concerned that the child learns to use money, learns to follow instructions, learns to ask for help if he needs it. This is part of preparation for placement, our crafts, hobby-type classes are valuable as means of preparation for placement in the community. One of the problems for the mentally retarded child is what to do with spare time, and if the child learns a hobby as part of the crafts program while with us, this is valuable preparation for placement.

Job Training of course, is one of our more important methods in preparation for placement. On the job training program the child works side-by-side with an employee doing the kind of work the employee does.

working with the painter, he learns something about painting, but he also learns that the painter works certain hours and does certain things in order to maintain his place in the community. This too, is preparation for placement.

Our cottage program takes up the bulk of the child's time and is geared partially toward preparation for placement, but mainly for care of the child while the child is with us. Some segments of the cottage program though are very definitely geared toward assisting the child in making the transition from institution living to living in the community. We have begun a program where children go downtown in Owatonna, taking their own money to make purchases. These shopping trips are proving to be quite valuable as a means of helping the child become accustomed to doing things by himself and for himself. We are trying to help the child in the use of his spare time by allowing him to go downtown unsupervised in groups of 3 or 5 to attend the movies. We have also begun a program of coordinating our religious activities with the activities in town and in the past two months a large number of children have attended church services in the church of their faith in town. This we hope, will make return to the community easier for them and will make the transition from institutional living to a life where they assume more responsibility for themselves easier. Our Volunteer Program should be considered part of preparation for placement. The children have an opportunity to experience a relationship with a person who is not professional, in the sense that they are employed in the institution. This kind of relationship is different, has a different meaning to the child and while it is early to evaluate the impact of the relationship, we believe that it does constitute part of preparation for placement.

To summarize, preparation for placement is not a magic formula, it is not something you do deliberately and consciously today because you have put it on your calendar to do it today. Preparation for placement is a coordinating of all activities, all pressures, all employee efforts in the direction of ultimately returning the child from an institutional setting in the community. It means gearing a program to the kind of activities that will make a child eventually independent and self-sufficient, rather than gearing a program to the kind of activities which make a person dependent and unwilling and unable to make decisions for himself.

I do not rule out the need for concerted and concentrated preparation in individual situations. I would point out though, that it is not realistic to talk about the concentrated preparation given in one individual situation, after it is known what the plans for the child are in the community, as so often we do not know other than the fact that somebody is working on plans to get a child into the community just what the plans are for the child. We often do not know much more than a general vague kind of plan that the child will have a job, have a place to stay and approximately when he will leave us. It is not possible for us to do a job of meaningful preparation in the sense of preparing the child for an individual situation. We must because of the problems of communication, the problems of getting children out of the school and into the community, concentrate our efforts on a broad every-day focus of preparation through coordination of all activities at the State School.

INSTITUTIONAL PREPARATION FOR PLACEMENT FROM FARIBAULT

Caroline Perkins

In an effort to screen a portion of our population who might possibly be considered for return to the community in a work situation, tables have been prepared of those patients who have intelligence quotients from about fifty and up to the borderline. The first one showing the distribution of this group by counties does not add a great deal to our knowledge as it is consistent with the population of the state. The more densely populated counties have the larger number of patients and vice-versa. (It also indicates that there are no longer many members from a mentally deficient family, so-called, who are sent to the institution without careful checking and community care given to them first, as used to be the practice some years ago.)

The table on the second page illustrates the age range in relation to the intelligence quotient. The tests used were generally the Stanford-Binet forms L and M, with occasionally the Wechsler-Bellevue, and the Kent for those with certain physical handicaps. As will be noted first of all, the total number of patients in this group (575) is only about 14.3 percent of our entire population. In other words, over 85 per cent of our population have I.Q.'s below fifty. Three years ago the number in the moron level was 21.3 per cent of our population. The replacements for those patients who have been returned to the community tend to be by persons of lower mental level, so that the number in the classifications for the severely retarded tends to increase, while the number of brighter patients decreases. A few who approach the I.Q. 50 were included, as they are patients who are receiving training programs here and who have mental ages of nearly 7½ years. They seem to be functioning more as morons than as imbeciles. This table does not mean that all of those with I.Q.'s below fifty are not placeable. It merely means that the chances are that fewer will be returned to the community, unless there should be a very supportive situation including a good home, economic sustenance, wholly, occasionally partially, and lasting provision for medical care and supervision.

It will be noticed that the larger number are the patients from 50 to 60 intelligence quotients and ages 20 to 60. Many of these are not capable of more than simple routine tasks, and would be very poor risks for gainful employment. Occasionally there are exceptions to this premise, as a case of a girl with an I.Q. of 54 who worked for years on an assembly line in a large mail order house, attaching labels, etc. to packages which were conveyed past her. She had saved her money well, and would not have been institutionalized if she had not become a very serious social problem. I also recall a boy who served in the war with the Army. His I.Q. was in the low fifties, but he was an orderly with the medical corps. When he visited us, he had memorized the instructions so that he could recite them letter perfect, yet he could read only very simple second grade level. By imitation, he learned his duties, and attended strictly to business, using all he had. We must keep the door open by observation and study, to see if any from this level might be placed, even if they do not have a favorable home environment to absorb them.

The various classifications below the table are intended to aid in interpreting the composition of the group. The readmissions, 61 for the males and 80 for the females, 141 in all, were returned usually because of inability to hold a job or jobs for any length of time. Also social maladjustment played quite a part, and in some instances, poor health. Some of these have been tried out several times, and usually returned for delinquency.

Those who had previous training at Owatonna, 34 males and 31 females, were invariably sent to us as being in need of a longer period of training and supervision in an institutional setting. Many of them had been real problems at Owatonna.

We thought you would be interested in knowing how few in this group were known to be married: 4 males and 49 females. The four fathers had 24 children, and the forty-nine mothers had 216 children. Of these children, 65 were known to be illegitimate, and 6 were still-born. Ten of the children are counted twice, as a man and wife are included in our patient group. About 7 of these children are at the institution today, and some 25 or 30 are at Owatonna. It means that as these children grew up, some in turn were committed as mentally deficient and came for institutional care and training.

The classifications in the second column have considerable overlapping and are merely estimates of the contributing causes which led to the institutionalization of the patient. Some patients had more than one cause. Those were selected which were "the last straw which broke the camel's back" and led to an emergency admission, or request for placement at the top of the waiting list by the county. The personality deviations range from temper tantrums, acts of violence against others, emotional upsets, to actual mental disturbance. Some have received previous care as mentally ill in state hospitals.

The inadequate home conditions refer to those who came from broken homes, or who had no home at all, or from homes in which the parents or the patients themselves were incapable of caring for their family or themselves. One wishes that one could have time to consider the more subtle forms of inadequate homes; as for instance, the home where the standards are high and the other members of the family are well educated. The mentally deficient one feels rejected and commits acts to compensate for the inability to compete with his siblings, only to win the approbrium of his parents. In one instance we know of the caseworker placing such a patient away from the home in a work situation, to try to build up self-confidence and esteem in what she does on her own initiative, at least she can think that it is her own initiative.

Recently about 13 of our brighter patients were considered for placement and recommendations were in order. However, only one has the resource of going to an acceptable home due to the fact that a stepbrother has grown up, married, and is now giving her vacations which are approved by the welfare board.

If the problem which the mentally deficient one presents affects the community to a marked degree, then the term community social problem is used. It may or may not include poor home conditions, although usually it does. The case becomes a serious social problem and is often involved in stealing, car prowling and theft, gang participation, shop-lifting, immorality and other anti-social conduct, including sexual deviations. An estimate has been made that about 150 of our group comprise this classification.

Those with serious physical handicaps (138) comprise the cerebral palsied who are in wheel chairs,while others walk only with difficulty. About 15 are blind, and about 20 are deaf or quite hard of hearing. Some have heart and other debilitating physical conditions which rule out exertion except for very light tasks and participation only in limited recreational programs. Without exception it can be said that all 138 of these are unemployable.

As you know, the institution has a program of good physical care under a staff of well qualified physicians and the benefit of consultants in all specialized fields. Psychiatric and psychological services are available. In addition, religious services and Sunday Schools are a regular part of our institutional program, and counseling is given to any patient who requests it from the Chaplain. The hobby, handicraft, and music therapy, as well as a recreational program, are aptly maintained by a recreational staff under a therapies and rehabilitation director. Another member of this staff, a patient placement officer, sees that our patients are given a work training program suited to their capabilities and inclinations. This program is recommended at a Case Conference which is held for all new admissions and for other cases within the institution which are in difficulty and maladjusted. It is not possible to train job for job for many reasons. One is that it is not known what kind of work will be available to the patient who might be returned to the community some time later, and another is that the patient helpers play a very important part in keeping up the routine tasks required in the institution so that it is necessary to effect a compromise and try to place the patient both in accordance with his abilities and in accordance with the needs of the institution. We do wish we could be more flexible in this respect, and if the time ever comes when there is more employee help and opportunity to really do a variable on-the-job training of the patient, then we will feel that much has been accomplished.

You will note that no mention was made of the 27 children who are in the School Department receiving a part time academic program and who are noted below the second table. The School Department reaches about 140 children, including a few of the young adult cripples who are taught by a visiting teacher who goes to the infirmary type buildings where they are housed. The trainable group or those with I.Q.'s below fifty, make up the rest of the school proper. Plans are being made to send a teacher to our young trainable children in our Pine and Spruce buildings to have a part-time nursery school.

Perhaps the institution needs an adult educational type of facility for our prospective placements. At this time, there are not enough teachers to put on such a venture, yet we can anticipate it. Such a class might fill in the gaps for those who need remedial reading, letter writing, conversational expression, use of a telephone, familiarity with making change, simple practical problems in arithmetic, etc. Each case would be studied individually and psychologically. Then the teacher and the staff members would participate in planning what should be emphasized in the class program. Many other practical subjects might be mentioned as possibilities for inclusion. One might even dare to suggest that attention might be given to training in acceptable social conduct, manners, personal hygiene, all of which are now the responsibility of the aides in charge of our patients. Everyone concerned would cooperate with the aides in such a program, and make it a "taken-for-granted" feature, so that when a patient goes out, he or she is better equipped to fit into the boarding place and seek employment, or into the rest home, or work home placement, or whatever the situation might be.

In conclusion, one might say that the number of institutional cases which might be considered as potential material for placement in a work situation is diminishing, but with those whom we do have, we should not falter in our zeal to prepare and train them for a possible return to the community. We should devise new methods of rehabilitation as well as we can with the resources at our command.

FARIBAULT STATE SCHOOL AND HOSPITAL January 19, 1957
TOTAL POPULATION 3,305 - per cent of population in table - 14.3%
(includes 88 at Lake Owasso)

COUNTY OF RESIDENCE OF PATIENTS WITH INTELLIGENCE QUOTIENTS OF FIFTY AND OVER

COUNTY	M	F	COUNTY	M	F	COUNTY	M	F
Aitkin	1	3	Isanti	1	0	Pipestone	1	0
Anoka	1	3	Itasca	1	4	Polk	3	0
Becker	0	1	Jackson	0	0	Pope	1	1
Beltrami	4	7	Kanabec	1	1	Ramsey	33	42
Benton	3	6	Kandiyohi	3	0	Red Lake	1	0
Big Stone	0	4	Kittson	0	0	Redwood	3	3
Blue Earth	1	2	Koochiching	3	2	Renville	6	1
Brown	3	3	Lac qui Parle	0	0	Rice	8	1
Carlton	2	1	Lake	0	1	Rock	1	1
Carver	0	2	Lake of the Woods		1	Roseau	0	1
Cass	6	7	LeSueur	0	3	St. Louis	16	27
Chippewa	2	0	Lincoln	1	0	Scott	1	3
Chisago	1	2	Lyon	2	1	Sherburne	1	1
Clay	3	2	McLeod	3	0	Sibley	0	0
Clearwater	0	2	Mahnomen	1	5	Stearns	3	5
Cook	0	1	Marshall	1	1	Steele	2	0
Cottonwood	2	3	Martin	3	0	Stevens	0	0
Crow Wing	6	8	Meeker	2	2	Swift	1	3
Dakota	5	6	Mille Lacs	2	2	Todd	4	2
Dodge	0	0	Morrison	3	3	Traverse	0	0
Douglas	2	0	Mower	5	5	Wabasha	0	4
Faribault	4	3	Murray	0	3	Wadena	1	2
Fillmore	1	1	Nicollet	1	0	Waseca	1	4
Freeborn	2	1	Nobles	3	1	Washington	2	4
Goodhue	4	3	Norman	3	1	Watonwan	2	3
Grant	0	0	Olmsted	5	8	Wilkin	1	0
Hennepin	54	66	Otter Tail	5	3	Winona	6	4
Houston	2	1	Pennington	2	0	Wright	2	2
Hubbard	4	2	Pine	2	3	Yellow Medicine	2	3

FARIBAULT STATE SCHOOL AND HOSPITAL January 19, 1957

POPULATION ACCORDING TO AGE AND I.Q.
(I.Q. 50 and over)

I.Q. RANGE	AGE RANGE Under 20		20 to 30		30 to 40		40 to 50		50 to 60		60 to 70		70 and over		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Just under 50	1	3	4	5	1	7	3	4	4	3	0	2	0	1	38
50 to 60	24	8	32	35	40	35	28	36	19	29	8	15	1	1	311
60 to 70	6	8	12	19	23	20	15	19	7	14	3	3	0	2	151
70 to 80	7	1	9	12	8	7	1	6	2	1	2	2	0	1	59
80 and over	0	1	2	1	3	3	2	1	1	1	0	1	0	0	16
Subtotal	38	21	59	72	75	72	49	66	33	48	13	23	1	5	Males 268 Females 307
T O T A L	59		131		147		115		81		36		6		GRAND TOTAL 575

Readmissions: M. 61 F. 80

Previously at Owatonna: M. 34 F. 31

Number known to be married: M. 4 F. 49

Number of children known to be born to these marriages and others: 24 Offspring 216

Number now in institution school: M. 17 F. 10

CONTRIBUTING CAUSE AT TIME OF ADMISSION

Personality deviations: M. 46 F. 49

Inadequate home conditions: M. 97 F. 142

Community social problems: M. 89 F. 71

Serious physical handicaps: M. 71 F. 67
(some developed later)

INSTITUTIONAL PREPARATION FOR PLACEMENT FROM CAMBRIDGE

Betty L. Lenz

We hold the philosophy that preparation for placement is a continuing process which begins the day the patient is admitted to Cambridge State School and Hospital. Our goal is to help each individual attain the highest level of social maturity, within his limitations, which will enable him to adjust to community living.

A new era in better patient management began at Cambridge in August, 1956, when, as you no doubt know, Dr. George L. Wadsworth, our new superintendent, came to us. A great many constructive changes have been effected since that time, and many more will be put into effect in the future. Because we are in a state of transition, this paper will tell you about the things we have done in preparing the patient for placement, things we are going to do, and things we would like to do and may be able to bring to pass.

We feel that the team approach is the best basis on which to plan for the patient's total adjustment to institutional living and to prepare him for an eventual return to community life. The scope of our team membership is wide, for we think this is the best means of obtaining a "total approach" in the preparation of the patient for placement. The membership of our team is as follows:

I. The institutional staff which includes these members: The Medical Services, The Director of Medical Services, Staff Physicians, Dentist, Psychological Services, Social Service, Nursing Service, Patient Activities Service, Intra-institutional Work Placement Service and the Chaplain. The Director of Academic and Vocational Education Service is also an important member.

II. The Social Workers of the County Welfare Boards.

III. The Section for Mentally Deficient or Epileptic.

IV. The family of the patient.

V. The patient himself.

Progressive planning for placement preparation will be implemented in the following ways:

I. We are planning to have a <u>Staff Admission Case Conference</u> which will be presided over by the superintendent or the medical director. Through the case conference at which the patient is seen we will be able to individualize plans to meet the patient's needs. The social workers of the county or counties who have worked

I would now like to discuss with you the factors to be considered in determining a patient's readiness for a community work placement. As you all know up until 1953, we were an institution for individuals suffering from epilepsy; we are now an institution for the mentally deficient or epileptic. Consequently, at the present time the majority of the patients who will be considered for placement are epileptic. For that reason the discussion will be oriented to the problems connected with preparing and placing an epileptic, who may or may not be mentally deficient.

The factors taken into consideration are these:

I. Physical Condition

Seizure control; general health, physical disabilities; height, weight and strength as it may affect a work placement.

II. Educational Achievement

III. Personality and General Adjustment

1. Ability to get along with other people - individually or in group activities.
2. Emotional stability.
3. Response to frustration.
4. Morals; that is, concepts of right and wrong.

IV. Personal Habits

1. Cleanliness and orderliness.
2. Personal appearance.
3. Care of personal belongings.

V. Attitudes toward Work

1. Willingness to accept supervision.
2. Willingness to do his share.
3. Willingness to accept responsibility and to show initiative (within his limitations).
4. Punctuality.
5. Ability to get along with co-workers.
6. Complete assignment (no thoughtless quitting of job).
7. General deportment and dress.

VI. Ability to use leisure time.

As previously stated we feel the team approach achieves the most satisfactory results in training and preparing a patient for a return to community life. This means there must be coordinated planning and effort on the part of all employees who work with the patient. Therefore, let us look at the contributions of each member of the team:

with the patient and his family will be an unseen but extremely important member of the case conference, for the social history and other pertinent data which is forwarded to us is an invaluable aid in helping us to understand the patient's needs and problems. This information plus the studies made on the patient by the staff will be discussed and utilized in making plans for his institutional adjustment; that is, medical, educational, or vocational plans, work plans, and the assignment to the cottage in which he will live.

II. Plans are being made to set up a <u>Disposition Clinic</u>. The clinic will be presided over by the superintendent or by the medical director, and will be attended by the staff. The plan is to have each patient in the institution presented at the clinic once a year. Through the clinic progressive planning for an individualized approach to each patient's treatment can be facilitated. Each member of the staff will contribute his knowledge concerning the patient; thus, a more objective understanding of his needs will be gained. Again the social workers in the counties are silent members of the clinic, for past and current information forwarded to us by you can be utilized in planning for the patient.

The <u>Disposition Clinic</u> also provides means for a re-evaluation of the patient's progress. If, for example, we feel a patient is a potential candidate for a community placement, he will be referred to the Disposition Clinic. There his readiness for a community placement will be discussed. His strengths and weaknesses can be evaluated. The areas in which he needs to make more progress will be indicated; consequently, plans can be carefully formulated to help in those areas. For example, he may need more help concerning attitudes toward his work. The patient's case may be presented as often as is felt necessary. This process we hope will help prevent failures of placement, for we feel it provides a means of better planning to prepare the patient to live in the community.

Again the <u>Disposition Clinic</u> will be utilized in making a carefully formulated placement plan when we feel he has demonstrated a readiness for a community placement.

III. Our <u>daily staff meeting</u> is another means of implementing our continuing plans for placement preparation, for if the patient is developing emotional problems, or is having adjustment difficulties in the cottage it will be brought to the attention of the staff during the reading of the daily reports.

I would like to reiterate that the personal contacts with the county social workers, the written reports, and letters written by them concerning the patient are valuable to the institution staff in our progressive planning for placement preparation.

First, and most important of all is our Superintendent, for it is he who draws up the over-all policies for the therapeutic treatment of the patient. Under his able guidance we can attain our goal; that is, an individualized plan that will enable each patient to reach his best possible total adjustment.

Next in importance, is our Medical Director who is the immediate supervisor of the members of the team who are in the medical services. It is with him that we discuss our plans and special problems for an individual patient, and it is he who keeps the plans integrated into a "total approach" for that individual patient.

Our Staff Physicians are not only mindful of the physical health of our patients, but they also listen to patients' day to day problems and give them counsel. If they feel the patient's problem should be referred to another member of the team, they will do so. For example, the psychologist, the social worker, work placement officer, or the problem may be referred to the medical director and thence to the Disposition Clinic. The patient's parents often ask for an interview with the physician regarding their child's progress.

Our Dentist is also a member of our medical team caring for our patients' health problems.

The Psychologist also makes valuable contributions toward total plans for the patient in the following ways:

A psychological study of all new admissions for the purpose of making recommendations to the Staff Admission Case Conference at which plans are made for the patient's training program.

The diagnostic studies made by the psychology department will be used by the Disposition Clinic in making plans for the patient; for example, determining the patients aptitudes when plans are being made for a work assignment within the institution, or for a work placement in the community, or in determining his level of academic achievement, his need for individual therapy or group therapy.

Our psychologists have participated in our in-service training program for our nurses and psychiatric aides.

Recently our clinical psychologist held sessions in group therapy with a group of girls whom we felt might be potential candidates for community placement.

The Social Worker is also a contributing member of the therapeutic team plan for placement preparation. On the day of admission she helps the physician receive the patient and his family. At that time she explains the policies and procedures of the institution to the family; that is, our policies regarding visits to the patient during his institutionalization.

Also, the policies regarding visits and vacations by the patient away from the institution are explained. In relation to the family she helps them handle their feelings regarding separation from the patient.

The social worker is a member of the Admission Staff Conference. Information concerning the patient's social background and social problems is of importance in planning for an individualized approach to his training and preparation for a possible future work placement.

Following admission the worker for the first few weeks follows the patient's adjustment and helps him with his emotional problems so that he will be albe to profit from the various aspects of his training. This is important, especially if the patient has potentials for a work placement in the future, for from the time of admission the goal of our therapeutic team is to motivate the patient in every way to achieve the maximum of his potentials.

The worker also is a member of the Disposition Clinic and participates through presenting information concerning the patient which she has gained through working with the patient and his family. The worker actively participates with the group in pre-placement plans.

When the patient shows readiness for placement she works with him, for we feel the patient, to the extent of his ability to do so, should participate in all plans. Many times the patient's level of aspiration is far beyond his ability to achieve; therefore, he must be helped to accept the reality that he will need to accept work within the range of his ability.

During the patient's institutionalization the worker, always under the supervision of the medical director, helps the patient with his problems, always keeping in mind the service should help the patient attain the greatest level of social maturity within his limitations, so that he may be better prepared to succeed in a work placement.

The worker helps prepare the patient to leave the institution, for inevitably he will have some feelings of anxiety regarding leaving the security of the institution and facing the problems of a work placement. Also the worker explains to the patient the meaning of commitment to guardianship and in conjunction with this, the role the county social worker will have in supervising him. We advise him to discuss his problems with his county worker.

A Social Service Report is another way in which the social worker has been assisting in the institutional preparation for placement. When plans for a placement are initiated the report is sent to the county or counties involved, with a copy to the Section for Mentally Deficient or Epileptic. The purpose of the report is to give the county workers information on the patient regarding his social adjustment and personality traits, his work adjustment, academic achievement, and physical condition, which will help them plan or structure the placement.

All members of the Nursing Service participate in the preparation of the patient. A very important contribution is made by the psychiatric aides. In fact, the greatest responsibility rests with them, for it is they who work most closely with the patient. It is through their day to day guidance that the patients learn to adjust to others, learn good personal habits, and learn wise use of leisure time.

Our Patient Activities Service gives the patients an opportunity to learn how to make good social adjustments in group activities. The following are some of the recreational programs which they provide for the patients: weekly dances, basketball, soft ball, movies, dramatic club, art class, ice and roller skating, picnics and birthday parties. Recently a program was started through which the patients are taken downtown on shopping trips and are given the opportunity to attend the basketball games of the local high school. The recreational workers try to help the patients with their inter-personal relationships. All this is a valuable preparation for a work placement.

Recently an Intra-institutional Work Placement Service was put into effect. The work assignments are made on an individualized basis and only after a very careful study of the patient's needs and aptitudes. The work assignment gives the patient an opportunity to learn on the job and to learn good work attitudes. It is a practical method of evaluating the patient's ability to adjust in a community work placement.

The Chaplain Service also serves an extremely important function in preparing the patients, through giving them spiritual guidance and teaching them moral responsibility.

That the Director of Academic & Vocational Education Service is an important member of our team in preparing the patient for placement, is beyond a doubt. The director and other members of the team hope that an adult education class can be started for remedial education, for we have been long aware of this need, and are also aware that county workers have voiced a need for this service for institutional patients.

I wish to reiterate that we feel the County Social Workers are essential members of our team. Visits and vacations by the patient in the community help him keep in touch with community life, and are a means of effecting the often difficult transition from institutional living to community living. It has been very helpful to us when the county has sent us a report concerning the patient's adjustment during a vacation, for then we can determine the areas of strength and the areas in which the patient needs more help in order to adjust successfully on a work placement. We have also found that conferences with the county workers at the institution are very helpful for these reasons: The plans for the patient can be discussed; the workers, institutional and county, can discuss the plans with the patient who then feels that he is also actively participating in the plans; the contact with the patient helps in the transition from institution to community.

Another contributing member of our team is the <u>Section for Mentally Deficient or Epileptic</u> which acts as liaison between the state institutions and the county welfare boards. The section sends appropriate suggestions and recommendations regarding placements and participates in case conferences held at the institutions.

The <u>family</u> also participates in our preparation plans through their contacts with both the institutional staff and the county case workers.

The <u>patient himself</u> is the most important participant of our team, and central to all the preparation plans for placements, for he is <u>not</u> a person to be acted upon, but an individual who should be motivated to let us "help him to help himself" within the limits of his potentialities.

In closing I would like to repeat that in preparing a patient for placement our goal is to help each individual attain the highest level of social maturity, within his limitations, which will enable him to adjust to community living.

INSTITUTIONAL PREPARATION FOR PLACEMENT FROM THE ANNEX FOR DEFECTIVE DELINQUENTS

Ralph Rosenberger

In the fifteen minutes alloted to me to discuss Institutional Preparation for Placement from the Annex for Defective Delinquents there are some facts that I think should be emphasized.

In the first place, we feel that all of the patients sent to us are trainable. It would be quite exceptional for us to have a case that we believe is hopeless and needs constant supervision or institutionalization for life. We feel that everyone who comes to the Annex for Defective Delinquents is going to be given a chance to make an adjustment. Perhaps we are a bit optimistic in our feelings about adjustment but dealing with personality maladjustments is our business.

We feel that the mentally retarded who come to our institution are lacking not only in a mental capacity but also in a social-moral sense. We have found that the personality disturbances and weaknesses that have made the patients delinquent are their most serious difficulties. When a mentally retarded person misbehaves there is a reason for it. Usually there is just as much personality maladjustment in the retarded as in the normal people who misbehave. Misbehavior, as such, is purposeful and is usually a misguided effort to secure some sort of satisfaction. Such misguided behavior of our patients should never be excused on the basis that the patient is dull mentally and does not know any better. All of our patients fall in the moron classification and patients in this category know the difference between right and wrong. In the final analysis, retarded persons are behavior problems because they are attempting to secure some sort of satisfaction.

Thus it is our task to substitute, in a concrete way, opportunities and outlets which can successfully compete in interest, excitement, and satisfaction with the undesirable and anti-social activities. In other words, instead of being the problem child in the neighborhood, instead of being lazy and shiftless, let's be the best worker, let's be the best sport on the recreational field, let's be the kind of fellow that the rest of the group would like to work next to because you are doing your share.

I feel that good personality involves definite social skills and can be acquired with proper training. We can develop personality through situational responses, through programming, through opportunities to change personality by responding to correct choices. I feel that the basis of our whole training program is to develop acceptable personality skills through a program of occupational proficiency and personal adjustment, through the changing of concepts by providing opportunities to make correct choices. We need to work at it from every known angle if we are going to change character or personality weaknesses. We need to work at it

24-hours-a-day. We need to have mental hygiene or group therapy classes in which we can discuss honesty, cleanliness, work habits, personal habits, and responsibilities. It is important to learn through personality builders. In these class situations plus concrete life situations we are developing social skills that will result in an acceptable community adjustment. While the program at the Annex is primarily concerned with training situations and work habits, it is also compulsory for each patient to attend a class in mental hygiene. In these classes it is important to discuss such things as public responsibilities, social factors, and personal problems. The patient must recognize that he has a responsibility to people, that he has a responsibility to his neighbor, that he has a responsibility to his fellow worker, that he has a responsibility even at play. He must learn that we cannot always have our own way, that we give and take and it is important to do those things.

We have been guided in organizing a retraining program for the adult person with mental deficiency by the belief that the major portion of any plan designed primarily for the defective delinquent should be concerned with giving the patient insight and a broader and clearer conception of his relation with society. All projects, discussions, and work placements should be with actual life situations and through proper guidance should arouse in the patient a healthy attitude toward such situations. A retraining program needs to be a 24-hour-a-day program. The standards of behavior that are set must be adhered to in recreation, in the dining room, in developing work skills in a shop, or in their living quarters. There are certain limits and standards that must be adhered to in all situations. We can never let down. It must be remembered that the mentally retarded can achieve. The retarded in our category can achieve sufficiently so that they can go back into society and adjust. They can, in most cases, become self supporting and it is important that they do so.

In conclusion, I receive a small monthly newsletter from the Polk State School and I should like to quote an item from their publication.

"The past six years have shown a great change in the attitude towards mental retardation. A strong national association of parents and friends has developed. Funds for research are beginning to be more easily obtainable. The future is brighter than at any time during this past century."

"Much of how much is accomplished will depend upon how well the average citizen accepts the problem of the mentally retarded. We all must learn that the average mental defective does not require permanent institutional care. We must remember that many of those currently in institutions similar to Polk could be home with their families if the community were more tolerant and the families would face the fact that they could have their child with them at least on a part-time basis."

"We must recognize that mental deficiency is not a tag that should be used to set these persons aside from the rest of life."

JOB PLACEMENT AS SEEN BY COUNTY WELFARE BOARDS

Harold F. Mickelson

Yesterday, you heard the legal basis for the State's program in caring for the mentally deficient and epileptic. You heard something about the relationship between the Department of Public Welfare and the Welfare Board. You also heard from Mr. Engberg about the Institution's relationship to the County Welfare Boards.

Development of the Retarded Child's potentialities was brought out clearly in the afternoon sessions. The topic today is centered around the retarded adult. Some of my remarks may be repetition of what has already been said by others. The subject is one that encompasses the services of <u>many</u> and <u>separated</u> agencies. The closest cooperative effort must be put forth for a successful plan in placing the adult out in a community and providing adequate supervision. This plan naturally brings the County Welfare Board into the picture. Decentralization of a program with state supervision and county administration is perhaps the closest we can come to an ideal arrangement. This was recognized as far back as 1937, when County Welfare Boards were organized, in fact it goes back to the days of the Child Welfare Boards.

Chapt. 303 of Minnesota Statutes established County Welfare Boards. The law clearly defines its functions, duties and it imposes certain obligations upon the Welfare Board to render welfare services to the general public. This <u>broad</u> statement is found in Sec. 303.07, Subd. 2 of the Statutes. In substance it also charges the County Welfare Boards with duties as may be imposed upon it by the Commissioner of Public Welfare.

In the 20 years of existence, Welfare Boards have become well established in their programs. Some have progressed more rapidly than others in their thinking and planning for social service. Their ex-officio leader is the Executive Secretary. He or she has the vital role of leadership to plan in the development of community service. I lay this responsibility primarily in the lap of the Executive Secretary. He must train, educate, guide and lead his Board as well as Staff in the adoption of good social thinking and in the development of sound planning and action.

The Welfare Board has a wonderful chance to play a dynamic role in the field of social work not only on a state-wide basis but locally. In the first place the Board is "at the grass roots" of the problems. It is on the "ground floor." The Board members <u>can</u> and <u>do</u> apply their <u>good</u> common sense to the programs layed down for them by the laws of the state and the regulations and rules set forth by our Commissioner of Public Welfare. The Board member is <u>the Public</u> as well as a member of the Executive Staff that carries out mandates of society in terms of legislation, that is, to care for all the social needs of our state. Therefore, it behooves the Board members to acquaint themselves with all the problems in their department. The Welfare Board which I shall refer to as the County Agency from time to time, has numerous programs to administer. Some of the programs are purely financial. Others, are a combination of financial and social service or merely service. The financial program is perhaps the easiest to administer as long as we provide adequate finances. The social service programs are a combination of finances and a professional case work approach to problems. This is the point at which we must clearly define our role to the Board member and the public. Placing a dollar and cents value on certain service programs is difficult to interpret to the public. It cannot be done in a few days. It takes patience, time, and a purposeful presentation to tell the public why we do certain things. The Board member plays a key role in interpreting to the public these social services.

We are here to discuss the Job Placement of the mentally deficient as seen by the County Welfare Boards. From my few previous remarks, you can see how important it is that the Welfare Board members know what their responsibilities are.

I believe that there are three ways of defining this responsibility. The first would be the legal obligation to provide care and service as the law requires. I mentioned this point in the very beginning. To elaborate a little further, however, I would like to bring out an additional thought. We use the term "legal residence" so much and apply it most frequently to poor relief settlement. The mentally deficient person is protected by such a law also in that he or she maintains a settlement in some county. Generally it is the county of commitment but not necessarily always so. In any event some one county is responsible for that person's well being. As it was our responsibility to commit that person it is likewise our responsibility to provide for that person's well being in the future. The sooner we think of that retarded adult as a person and not as a statistic in the institution, the quicker we will understand our role in the community. When we think of him as a person we think of what we should do for him and what we can do for him. It stirs our thinking process to the point of positive action. The easy way is to "commit and forget." But - is this morally and socially all we have to do? These are the other two points I wish to bring out.

Of course, we have a moral obligation to "be our brother's keeper." If someone in the institution can possibly be rehabilitated on a job, do we not, as Board members, have a moral obligation to help that person return to society? As a resident of my county this person has a right to request service of us so that he may again take his place in society or at least have the chance to try outside placement. I firmly believe this to be a basic right.

Why are our institutions increasing in population? Discharges are not being made as rapidly as they should is perhaps one reason. Where is the lag? Generally, it might be our overall discharge plan. It might also be reluctance on the part of Welfare Boards to recognize the moral right of that person to have this chance outside. It is a known fact that the community, and pinning it down more closely, the neighborhood, feels they have done their duty by protecting society when they have accomplished commitment of a person. The community drops the matter then, having removed an evil influence or social hazard. Isn't that community morally obligated to continue following the case even though the person has been removed? The Court of commitment has performed its function. It then becomes the obligation of the County Agency to offer its services to the institutionalized person.

This leads us into the third factor - the social obligation. The medically ill person seeks a solution to his problem by entering a hospital, or he may receive clinical treatments. He is discharged to a nursing home or his real home when the doctor deems it advisable. Sometimes follow-up home treatment is necessary. The Public Health Nurse may be called upon to look in on the patient to render service. The Welfare Agency may be asked to help find a suitable rest home - and we do give service of this nature in connection with our Public Assistance program. We provide for all the medical care for an Old Age Assistance recipient. We buy glasses, hearing aids and dentures to make life more comfortable and purposeful for these people. These are services taken for granted nowadays. What do we do for the retarded adult when he should have a chance to adjust in society after making a satisfactory adjustment in the institution? Probation and parole services have been extended for the law violators. Minnesota recognizes this as a fundamental right of these persons. Wouldn't this be true also of a mentally deficient person who has been in an institution for a period of time? Certainly he has received the best medical diagnosis and treatment available. He has certainly been trained to do things commensurate with his abilities. He has learned a work habit and adopted a pattern of living under the skilled supervision of the Institution's professional staff. Why should he be different from the physically ill person who returns home - or the mentally ill person who is discharged under a plan whereby he can get professional case work services of the County Welfare Board or the parolee from the St. Cloud Reformatory. The Interim Commission on public welfare is recommending Mental Health Centers throughout the state to provide additonal services to the mentally ill of our state.

Where else than the Welfare Board would the mentally deficient person turn for help in seeking a job? It all goes back to the fundamental right to expect the help needed when facilities are set up for that purpose.

Certainly it takes time and money to plan for outside placement. Visits to the institution and interviews with both the person and institutional social worker are merely the beginning. It may take more than one interview. When possible it is most helpful if the representative of the Minnesota Employment Service can interview the applicant as well. This has been successful in our placement plan. The Welfare Board must be prepared for reverses in the plan. Not always will the first placement prove successful. A period of reapplying may require the expenditure of money for maintenance until other employment can be found. These are details the Board should be made aware of in the initial planning stage.

These should be thought over carefully and fully with the details left up to the administrative head.

County Welfare Board members must be able to answer to the public for some Agency plans occasionally. It is most important that all members become understanding of all phases of this placement program. When they know these details I have found them to be in full accord with any reasonable placement plan. I could enumerate several plans we worked out and one that stands out most vividly is Mr. X. He was released, entered military service, came out of the Army a Master Sargeant, engaged in construction and contracting work. He has always spoken well of the help he received during his discharge process. He has since assisted other men to come out of the institution by providing a home and employment for them temporarily. Needless to say guardianship was discharged eventually. Today Mr. X. could almost go into a finance business with his earnings. Not all cases are so successful but is every medical case leaving the hospital a complete success? Are all parolees from St. Cloud a success? The Welfare Board must be prepared to accept reverses and gear its program accordingly to profit by the failures and/or deficiencies in services.

We might ask what can the community expect of the Welfare Board and its staff? What can it expect of the State Institution? A chain is no stronger than its weakest link. The speed of a car is determined by its strength measured in horse power. The community has a right to know the problem in the first place. The interpretation of a problem to the community is essential in <u>solving</u> that problem. The establishment of local groups known as Friends of the Mentally Retarded is an excellent example of local interpretation of community needs. I commend these groups for their perseverance in making their needs known. I believe also the community has a right to know how the placement plan works. Interpretation by Welfare Agency personnel and Board members at community meetings is a good media. Radio, TV and speaking engagements are excellent means of telling the story.

The State Department has an obligation to develop the best possible plan for institutional care and training. Minnesota surpasses many states in this respect. The legislature must provide for the increasing needs of institutions with finances and staff. The institution has an obligation to provide the servicing County Agency with a complete history of the ward's adjustment under its care. We like to know the deficiencies as well as his good points. A fair evaluation of the patient's responsibilities is most desirable. Institutions dealing with the mentally deficient <u>do</u> give us this information.

Community acceptance of the Retarded Adult is something that must be proven by successful placements. It is our best advertising if you wish to put it that way. We must first <u>sell</u> <u>ourselves</u> on the plan; our Boards must be in accord with the program. Our community must be made aware of this growing need and they must <u>participate</u> in this plan. There are many organizations which are eager to assist in community problems. Find the group that we think will fit in best, explain the problem and I am sure they will lend wholehearted support. The one thing we must bear in mind, however, is that this person needs good supervision, understanding of where he can get this help and what is expected of him. Such service is available at the County Welfare Board level. It is free.

This morning you heard of the preparations made by institutions for placements. Yesterday, you heard of the development and use of local facilities. Tying together all these plans and resources is a function of the County Welfare Board. We have made tremendous strides in planning for placement. Let us continue to develop a sound and effective program, not only to make room for more people in the institution but to give the placeable person a chance he justly deserves.

COMMUNITY RESPONSIBILITY FOR THE ADJUSTMENT OF THE RETARDED CHILD, AS SEEN BY A PARENT

P. W. Rogers

As a parent of a three year old mentally retarded child, I would like to enumerate a few situations that have happened to us. When I asked myself why these situations arise, it was difficult to find a logical answer. It may be that being a parent I tend to be too subjective in my thinking, but when I discuss problems with other parents who do not have the privilege of having a mentally retarded child, they too cannot understand the existence of some of these situations.

The first situation was when the doctor, a leading pediatrician, recommended that the child be placed in an institution, particularly a state institution. The parent is at that time ready to follow the recommendation of the so-called experts. When you check with the welfare department you find out that your child may be committed; but as far as setting any definite date when that child can be accepted in a state institution, no one seems to be able to give you a definite answer. Perhaps if the medical man would co-ordinate his advice with the existing circumstances he could better prepare a parent for the keeping of a child until such time when an institution can make room for him.

The second situation is when one goes to the welfare board. There is no doubt a certain stigma attached to going to welfare, particularly if the person is not asking for any financial assistance. I am sure that the secretary of welfare in a rural county has a multiplicity of jobs, and after thinking over the objective I can see why the mental deficient could very well be given a lower priority than some of the more immediate problems, such as old age assistance, and the like. I have a definite feeling that the problem of the mental deficient has never been seriously impressed upon those in charge of the county welfare. As a resident of out state Minnesota I think the observation could be summarized that in too many instances the question of taxes interferes with the decision that these children are citizens and are entitled in their sphere the same fruits of government that the normal children are enjoying.

The next situation is where the social worker or the secretary of the welfare follows the plan that people know where he is and if they want help they can come to him, rather than to seek out parents of the deficient children, call on them and at least acquaint them with the various programs that the state welfare has. I know of several instances where we receive the statement that, "The social worker must be careful not to stick his nose in other people's business for fear they will resent it." I think that if you carry this to its ultimate limit many parents will be deprived of advice and "know how"; consequently could build up antagonism either toward society or to pull away from society and become full fledged introverts.

I think the first thing a parent must do to achieve the full benefits is to admit that they are the parents of a retarded child. They will then have the opportunity to discuss this with other interested people, laymen, if you will, in their own community. They will then become interested, not only in their own child, but all retarded children. The A. R. C. has been a lifesaver to many parents, including us. We belong to an organization composed of five counties. This was started because there were not enough parents in each county that wanted to admit their problem; at least were probably content that nothing was done in the past, so it was hard to believe that anything would be done in the future.

I know this is not a fair statement because I am sure that many children in our county have been helped, but because of the "hush-hush" no one is aware of what has been done or is being done to help both parents and children adapt themselves to this common problem.

To help solve this problem in my particular county, I can visualize an advisory board to the county commissioners or the county welfare, that could act as a "go-between" between the parents and the welfare office. This advisory board should be men of stature in the field of law, medicine, religion, nursing, business, farming and education. I think most of us will agree that if a board, as I described, could help to co-ordinate the different departments of the state, they could all work toward the solution of the mental retard rather than the building up of their own files and the fear of one department transgressing on the other and we could accomplish much to help these children.

There are many dedicated people throughout the state that have never had a chance to lend their ability to this program and not to cultivate this type of people is definitely a waste of manpower. There are no people on earth more interested in a fair and critical assessment of a job than those who have the problems themselves or have friends who have a problem. In fact this board would be from the "grass roots" and they could no doubt do things in contacting parents which the welfare department might hesitate in wanting to do.

My simple recommendation to this problem is just to keep one or two things in mind when talking about the deficient child. He was created by the same God as you and I, and he is a citizen of the same state as you and I. We do have the obligation to render him his rights that he has inherited from the same God and state as you and I.

COMMUNITY RESPONSIBILITY FOR THE ADJUSTMENT OF THE RETARDED CHILD, AS SEEN BY THE SCHOOL

Lettisha Henderson

The community concept of its responsibility for the mentally retarded has been undergoing gradual change, and since World War II there has been a rather extensive modification in its philosophy and in its program of action to provide more appropriately and adequately for this area of its population.

There is a growing regard for the retarded child as a real person, not as a negligible individual, but as a child with a personality, with feelings, hopes, and aspirations. He has basic needs the same as, and not different from those of normal children - of all other children. He is a child with a special handicap and with special needs besides those common to all children. Although there are great individual differences from other children, there are also likenesses to other children.

There is a growing demand to make special educational facilities available to all who can profit from special training programs.

After the enactment of compulsory education laws the schools began to experience the existence of mentally retarded children. The problem they presented to the regular classroom was handled largely at first by exempting them from school attendance. This is still common practice in too many communities. The school authorities in some districts considered these individuals the entire responsibility of public welfare organizations; in others they considered them a direct responsibility of the school system.

There were attempts on the part of some classroom teachers to handle these children with great individual differences in the regular class, but these attempts did not prove feasible.

Then ungraded classes were organized primarily for the relief of the normal classroom with a program of time-consuming but meaningless activities. There were opportunity rooms with emphasis on handwork and on removing the child from unhappy competition in the regular grade room. Later the special class center as a segregated unit isolated from regular school contacts and opportunities came into being.

All these were attempts to deal with the problem of the retarded child in a school setting. However, the special class center movement did tend toward a program designed for the retarded themselves. We learned of the potential of these children, that they too, had a contribution to society. This became, generally speaking, the "era of recognition." Since World War II we have progressed to an "era of acceptance." The approach is away from a program having a tendency to stigmatize to one of special service to meet special needs. Attention to developing an educational program is being directed to assessing needs, assets, liabilities of these children.

There is nation-wide interest in extending special education programs to the secondary level. School authorities no longer consider their responsibility to the mentally retarded discharged by providing a program within the limits of the compulsory education statutes.

Special education is becoming an integral part of the school system rather than a segregated program apart from it. The general aims and objectives are the same for the children in this program as for all others. Special education, however, goes farther and supplements the regular school program. For the retarded child this means extending his environmental limitations. The curriculum for him is based on modified methods and techniques. The curriculum content stresses the practical, the concrete, rather than the theoretical appraoch. There is need for specific teaching in most informal learnings. There must be motivation; centers of interest are utilized; remedial as well as developmental learning is necessary to enable the retarded child to develop in accordance with his capacity.

The trial and error approach used by the skilled teacher is not one of caprice but of design. In this program adjustment to meet the child's specific needs rather than attempt at adjusting the child to the educational program is the prime difference. These needs vary as much in the non-academic as in the academic areas.

Since World War II, special education is mushrooming. The demand is greater to provide schooling for every mentally retarded child, including the severely retarded, who may profit from it.

To meet the needs of all these children a variety of educational programs need to be organized. There will be need for public day school programs with both segregated and integrated or cooperative units, need for residential schools, state, county or some other geographic unit, for private day and residential schools, for supplementary home teaching, for special services - psychological, medical, agency - for clinical centers, etc. Special classes cannot operate to meet the needs of handicapped children without other community resources.

Education of the mentally retarded is a cooperative venture in which the various social agencies, other professional services, the church, the home, the community activities, all of which impinge on the lives of these children, contribute.

The educational program must also extend beyond the secondary school for the mentally retarded to develop use of his maximum potential. The age of 16 to 21 years where drop-outs occur and where the child is at his maximum growth is one of the most critical in terms of preventing social and economic failure. The Vocational Rehabilitation program, the sheltered workshops and other extension of services are the pressing need for this neglected state in the education of the mentally retarded. The schools have an investment in these children at this state.

Many become entirely self-supporting, some partially so, but many more could be fully or partially self-sufficient with supplementary educational services now generally available to only a few.

The responsibility of the community as the school sees it then is to provide or to make available special education programs for all children who are educable or trainable from nursery school level through high school with facilities to meet the varying needs of its children, and extension of educational services beyond the high school program to secure development of the individual to his full potential and maximum adjustment in adult society.

COMMUNITY RESPONSIBILITY FOR THE ADJUSTMENT OF THE RETARDED CHILD, AS SEEN BY THE NURSE

Esther Jacques

Some questions that may be asked are: "How can nursing contribute in helping a family with a mentally handicapped child? How can she fit into the team of other professionals who are helping the family, namely the social worker, the teacher, the judge, the doctor, the psychologist, and others?"

The nurse may be the first to know about the family with a mentally handicapped child through referral from the doctor or the hospital, or she may find the child when visiting the family for other reasons. In visiting in the home she assists the parents with the care of the child as she would any child in any family. During the visit she observes the health status of all family members and the relationships between members of the family unit. She listens and waits for parents to express their feelings about their handicapped child. Her own attitude must be one of acceptance and understanding. She can support the doctor in his diagnosis and interpret in detail his diagnosis to the parents. Through this she can also discourage shopping around from one place to another for help. When she feels the family is ready for further information, or preferably they have asked for it, she can explain to them the various services that are available and how they function. The parents then should be allowed to make their own decision.

I believe the social worker should have this information from the beginning because it is the social worker who will take over at this point. This service has been explained to the family.

Are all health problems in the family immediately solved and no more use for the nurse, or would some communication be desirable? Would it be possible to have meaningful communication between members of county agencies, teachers, and whomever else might be helping the family think through their problem, through planned case conferences? Would this tend to reduce duplication of services and give each of us in our own disciplines some extra time for the families whose needs seem to be most urgen t and who need more intensive service in guidance and counseling? Might this also result in economy in time and cost to agencies?

As the nurse sees community responsibility for the adjustment of the retarded child I believe there needs to be:

1. Meaningful communication between all community agencies.
2. Coordination of services - or someone to coordinate the services each has to offer.

3. That nurses have a contribution to make toward maintaining physical and mental health to parents and children and should be part of the team. But they need to recognize how and when another agency is to take over.
4. Frequent and continued interpretation of services that are available in the community.

The fact that a child is mentally deficient and living in a community need not be a detriment to that community. Rather, we'd like to have that community feel wealthier by that very child's presence. To face issues squarely is often times the best way to work out the problems and overcome community resentment and indifference and gain its approval and understanding.

Social workers may work with a retarded child of preschool age in an effort to obtain placement in special classes to meet the needs of education. Referrals to schools are frequently made so that parents and children have the opportunity of helping to decide pertinent plans concerning this education. Pastors are called upon to consult and console parents with children who have "special problems." Information about a child's home and the economic and social status of the parents is furnished by a social worker.

By working with the school, the need for psychological testing may be discovered and in the same areas, the social workers help the schools obtain these services. Parents then have the benefit of one more specialist to assist him in planning for a child.

Supervision of older children and adults who are employed is one of the areas in which a social worker helps towards achieving community adjustment of the retarded. It is important for the protection of these handicapped children and adults to make sure that every method possible is used to insure safety, fair treatment, adequate wage standards. To achieve this, a social worker is called upon to explain the needs and limitations of a child with a constant desire towards working out the best plan possible under the existing conditions.

Within the past few years, the growing number of organizations of parents and friends of the retarded have helped immeasurably, for we social workers find parent groups do much in the way of assisting new parents towards achieveing a greater understanding and desire to help the mentally deficient find their place in the community.

Then, in conclusion, the social worker is only one of a whole team of people interested and working with the retarded to assist them in achieving their rightful place in the community.

COMMUNITY RESPONSIBILITY FOR THE ADJUSTMENT OF THE RETARDED CHILD, AS SEEN BY THE SOCIAL WORKER

Ardis Seifert

The factors of community impact, the parent, and the home, the school, the church, and the social worker, all render their part in the adjustment of the mentally retarded child.

The previous panel members have already discussed with us their responsibility towards this adjustment. Now, what about the social worker? Where does she fit in the scheme of this adjustment? What can she do? How can she help?

A social worker frequently acts as a liaison member of a community ready to co-ordinate the services available from the various resource people in any one area. The resources available depend on the area involved, be it rural or urban, with few or many services available to meet the needs of the retarded.

The social worker may be called upon by a doctor to explain to newly informed parents of a retarded child, the facilities available in a local or nearby area for placement of this child. Parents consult workers in an effort to help them arrive at a satisfactory decision and plan for meeting the needs of a mentally deficient child. Often times, simply "lending a good sympathetic ear" to parents will help re-establish their confidence in themselves.

The problems of adjustment of a retarded child are many and complex in nature. It is not always possible to satisfy parents, or the community entirely. Extenuating circumstances frequently come up to undo the progress already made towards this adjustment. Misunderstanding also serves to oppose progress and development.

The worker from an agency may be contacted by parents to assist them with planning towards commitment with the eventual placement of the child in a state institution. Perhaps need for medical attention is present with little to offer in the way of meeting this goal in the local community and outside help is needed.

A retarded child's place in the community is and will be a long lasting problem. Will he fit in with other children? Will his behavior conform to that of other normal children? Will he be happy? Can he find a job? Many times we have heard the remark made that retarded children behave just like any other children behave, only more so. How true this is!

A social worker sees a retarded child in a community setting just as the children who are physically handicapped, children of mixed racial backgrounds, those with speech or hearing and vision impairments.

THE USE OF MENTAL TESTS IN THE DETERMINATION OF A CHILD'S ABILITIES

Phyllis Amacher

Any formal or legal definition of mental deficiency is likely to sound rather cold and impersonal when applied to a child who is close to us. The usual standard of mental deficiency is likely to be some such phrase as "is unable to manage his affairs with ordinary prudence." In contrast, we often think of professional people as defining mental deficiency just in terms of I.Q. We often can hear someone say, "He has an I.Q. of 43. He's mentally retarded." This too, may seem like an unfeeling or cut and dried description of a person but it must be remembered that this is merely verbal shorthand to the professional person who certainly realizes that there is more to a person than an I.Q.

What then is the relationship between these two definitions? What does I.Q. have to do with managing one's affairs with normal prudence? I would like to substitute the general phrase, "getting along in the world," if I may, for this is perhaps more meaningful to all of us.

Getting along in the world means many things to many people. Is our standard of success earning money, contributing something worthwhile to others, living a good life or a number of other things? We don't have to agree in order to see that people differ in their ability to succeed and for many different reasons.

There are many human traits and capabilities which can be measured only roughly or not at all. Who can rate a winning smile? Still we all know many people who have gone a long way with this kind of an asset. Other members of the panel will discuss briefly some of the unmeasurable factors that must be taken into consideration whenever one wishes to determine human potentiality. I shall try to limit myself to those aspects of behavior which we feel can be measured by the tests which psychologists now use.

There might be as many definitions of "intelligence" as there are of "success" and if any of you ever ask a psychologist to define this word, you might end up wishing that you had not started the whole thing. There are certain things that most people will agree on however, and one of them is that intelligence is just not one thing. It seems to be made up of a number of abilities, some much more important than others for different kinds of tasks.

Psychologists are likely to classify these abilities mainly into two groups, verbal and non-verbal. We all recognize that the person who cannot communicate with others in speech or in writing is under a great handicap. Verbal ability, however, is much more than the ability to communicate, rather it is the ability to think in terms of verbal symbols or words. We sometimes forget that we do most of our thinking in words until we catch ourselves talking aloud and then, perhaps with embarrassment, we make the excuse that we were just thinking aloud. It has been shown that there is a direct relationship between the complexity of the words we understand and the complexity of the kind of thoughts we have. People do not use and understand words unless they are capable of grasping the thought that word conveys. So with children their vocabulary grows out of the sea of words around them when they have developed the ability to understand the word and not just because they have heard it. In most mental tests, then, the measurement of vocabulary plays an important part and has been shown to be one of the best single indications of intelligence. This measurement begins at a very simple level where the child is asked the name of a ball, or to put his finger on the picture of the dog and this becomes increasingly complex as he must explain more difficult words or follow more complicated directions. In cases where there is a speech or hearing handicap, certain allowances are made or other tasks are set up to try to see if the child can understand what we are trying to communicate.

Another important area of intelligence might be called abstract thinking or the ability to generalize. This was illustrated to me the other day when I was walking through the fur department of a store, just looking, when I noticed a toddler wander over to a chair on which a mink stole had been casually draped. She reached up, patted it, and said, "Doggie, doggie." Of course she was wrong as this mink was no dog but she was showing the very beginning of the ability to generalize. From her past experience she knew that dogs were furry and when she was presented with something new and different, she was able to see that this too was furry and she carried over or generalized from the one thing that she knew to the thing that was unfamiliar. We can see this on a much more complex level when we see an adult presented with a new situation or a problem. Their first reaction might be, "I've just never run into anything like this before," yet as they begin to think about it, they draw on their past experience, things they have read about or something that happened to their sister-in-law and finally to pick out or abstract the things in those situations which were similar. Once this is done there is a background on which to begin to work out a solution. The ability to see and understand how things are alike and different grows gradually in humans.

We attempt to measure the development of this ability by having the child point out to us which pictures are alike or different, and then work up to designs, words and ideas. At one age we might ask him to explain how wood and coal are alike and then later at a more advanced level, how liberty and justice are alike. Different tests contain many ingenious ways of bringing out this kind of ability.

We all know what comprehension means and yet I would hate to try and explain it. All tests try to measure this vague ability which is a part of all the other factors that we try to measure. Tests measure this in various ways. Of course we are always interested in how well a child comprehends directions and is able to grasp what we want him to do. At a more advanced level we want to know if he understands the reasons behind things and therefore we ask questions such as: "Why does something happen?" "Why do people do this?" and "What would you do if...?"

Out of the whole field of non-verbal abilities, I would like to comment for a moment on just two. Motor coordination may not properly be considered as a part of intelligence but it is definitely a part of development and at least in the younger child it helps us see what he is ready for as we see if he has the coordination to pile up blocks, string beads or control a pencil. Until the control of the movements is there, we cannot expect the child to learn the tasks which involve those movements.

The ability to handle forms and shapes is an essential one in all kinds of practical tasks. This involves more than the skill in using one's hands, even more important is the ability to perceive or see how things go together. We have known adults who are just no good at mechanical work or can't lay out a dress pattern yet it is hard to understand why they can't do it when it comes so naturally to some of us. I was working with an eleven year old brain-damaged youngster a short time ago trying to cut a paper snowflake and though she understood that she wanted to cut V-shaped notches in the paper, she could not learn, even though I helped her a dozen times, to cut at a slant and then to make another cut going the other direction to join it. Most tests include a number of items involving space perception.

The time has already grown short and I have not even mentioned such things as memory, imitation or others but what I have tried to do is to indicate first some of the abilities that we try to measure, how those abilities apply to everyday life, and some of the actual things that we do in tests to get at those abilities.

I have left gaping holes in this subject, some of which will be filled by members of the panel. I wish only to assure you that tests are not just made up of thin air but after careful thought, they have been tried out on thousands of people and there has been study of how well they do what we expect them to do. There is a great deal of method behind our madness.

SOME CONSIDERATION OF HARD-TO-MEASURE TRAITS

Harriet E. Blodgett

It has long been demonstrated that intelligence tests provide the most useful single prediction of general life success. However, we have always used some supplementary types of information in planning for mentally retarded children - case histories, developmental and social information, anecdotal records, and the like. At the present stage of our thinking, attempts are being made to provide increased community opportunities and situations for some retarded children who can adjust to them and make use of them. Such attempts make it especially important to try to understand and include in our planning some other aspects of individuality, many of which are probably related to intelligence but which are not very well measured by present techniques, and which are important in the total picture of child adjustment. We need to develop ways of measuring some other characteristics of children more adequately - things which we now try to observe and evaluate, often on a somewhat subjective basis, but which perhaps can some day be measured more accurately and objectively. These areas include:

1. Physical and motor skills - coordination, balance, strength, dexterity, speed.

2. Emotional levels - behavior impulsiveness and control, levels of responsiveness, attitudes, frustration tolerance, resistiveness, aggressiveness, destructive tendencies, motivation, direction of interests.

3. Social - "getting along with people" skills, adequacy of communication, level of cooperation, relationships with others, acceptance of directions, supervision, authority.

4. Temperament, disposition, activity and energy level, persistence and sustaining of interests.

There are several ways in which such measures, if more fully developed, would help us. First, in selection of children for training programs of limited availability, choosing children in relationship to the kind of program and the specific patterns of abilities and disabilities shown by the individual children. Measures of non-intellectual traits would also contribute to setting up the content of training programs and determining the extent of response to training. They would certainly be of great value in studying and evaluating relationships between the child's characteristics and home problems, and thus would contribute to greater effectiveness of counseling efforts.

MENTAL TESTING AS AN AID IN DETERMINING CAPABILITIES

Maynard C. Reynolds

Standardization.

Miss Amacher has helped us understand what we mean by intelligence. Psychologists have the problem of deciding how to measure "verbal ability," "abstract thinking ability," "comprehension abilities," etc. They try to set up behavior situations in which a child can show his abilities in these various dimensions. It is sometimes said that the psychologist tries to sample the abilities involved. When certain procedures have been satisfied, with respect to standardization, reliability, and validity of these samples, the total scheme of techniques and scoring may be called an intelligence test.

There is a special problem in trying to measure things like intelligence, because we don't have an absolute zero point at which we can begin and because the unit of measurement to be used is somewhat unclear. In measuring height, for example, the situation is much more simple because we have a meaningful zero point and quite unambiguous units, such as feet or inches. In intelligence testing we have only relative measurements. That is to say, that we can only compare people with other people.

On whatever samples of behavior we choose we may need to know how four-year-olds act, and how five-year-olds behave, etc. Then we can compare an individual with an age group. With children, we often say they have an I.Q. of 100 if they do just as well on the behavior samples as average children their age. If they do as well as children somewhat older than they are, their I.Q.'s are above 100 by some amount. Similarly, children who do only as well on the "samples," or the test, as children of lesser life age, have I.Q.'s below 100.

Standardizing a test involves essentially two things. First, psychologists must decide to give the tests, OK "samples," in exactly the same way for all children. This does not mean that in testing a child their relationship with the child needs to be stilted, but the test itself must be administered in a standard way. Secondly, we must know how children in general behave in the test situation.

Although some tests are standardized on populations of very special types, intelligence tests are usually standardized on the general population. That is psychologists try to give the tests to a representative group of all children or adults in the country. They go through elaborate steps to make certain that the particular people they use in standardizing their tests are selected so as to be representative of the country as a whole with respect to educational opportunities, socio-economic level of the families, racial origin, rural-urban distribution, etc. Only in this way can the behavior of a single child on the test be compared meaningfully with children in general of our country.

It is by means of careful standardization of procedures for giving and scoring tests and by careful collection of data on the test performance of large numbers of representative children that psychologists can take advantage of the experiences of others. By reading the literature on intelligence testing carefully, I can know just how hundreds of psychologists have used tests and what their results have been. By following their procedures, I can compare a child with thousands of other children even though I haven't personally worked with them.

What I have said about standardization covers only a brief part of the work of the psychologist in constructing and using intelligence tests. Perhaps the most important problem is determining that the tests we use actually measure or predict the kinds of things we want to know about, but this is another problem. Adequate standardization is but one part, but an important part, of the psychologist's work and concern.

HOW TESTS CAN BE USEFUL TO THE SCHOOL SOCIAL WORKER

James K. Merrill

The best way I know of saying what I want to say, as a school social worker, is to talk about some real children I have known and the way the use of mental tests have helped me help the child.

With Cheryl, it helped us see that what appeared to be mental retardation was not, and so affected the planning made for her. Cheryl, age 6, came to my attention when the parents contacted me just before school started to talk about whether she should go to school or not. She talked and sang to herself, was unpredictable, had in the past pulled her hair out, and often sat and rocked herself for long periods of time. She would on occasion, break dishes and furniture when her demands were not met. Often she attacked her smaller brother. The school agreed to let her try out special class and we later arranged for a mental test by the state psychologist. The psychologist found, instead of mental deficiency, that there was a likelihood of a psychosis. This was later confirmed by a psychiatric evaluation. This of course made a difference in the kind of care the child would need and in the planning the parents needed to make for her.

With Robert, mental tests helped us get a more thorough evaluation of a condition that might have been corrected. Robert's behavior was bizarre and was reaching the point where the school was concerned about how much longer they could tolerate it. He chewed paper and pencils. He gave ridiculous answers to questions, orally and in tests. He broke into song. He would write and talk of trips to the moon and tell wild stories of things he had done. With the finding of epilepsy and brain tumor, there developed a better understanding of what we might do to help him, plus the assurance that with help he probably could finish school, even though there would be times when he could not control his behavior. Robert is finishing school only because the school has some knowledge of what is wrong and what to expect.

Mental tests have helped us understand why some children like Lewis appear to be lazy and indifferent. It was easier to understand Lewis' truancy when we combined the test results, indicating a mental age of 11, with a poor home environment where there was no encouragement to attend school.

Mental tests have helped us to interpret to Rollands' parents how unreasonable they were being in taking the position that, "Rolland will finish school if he has to go until he's 25 years old."

Rolland was a most unhappy boy, tall, gangly, and not good looking. He wore thick glasses and had a kind of head tossing nervous mannerism that did not help his appearance. He was getting nothing from his classroom activities and in the past two years had been causing considerable disturbance in his special class in Junior High School. His teachers said he wasn't a mean boy, but he kept busy fooling around.

Slowly, as we were able to help his mother see that Rolland could not complete school, even if he did stay until he was 25, she began to relax with him. Up until she fully accepted the idea that Rolland was some seven years retarded, she had berated him, tried to bribe him, and forced long hours of study on him. I am sure that she knew something was wrong all the time, but it took the use of the test results and what they meant to help her see that there was more to it than just being "slow." It came much too late, however, for Rolland has since been enticed into petty thievery by shrewder friends.

The situation can be bettered by starting just a little earlier, as we were able to do with Peter, age 11. His I.Q. was about 50, he was pugnacious, hostile, and was treated poorly by a mother who didn't understand him.

I feel that we need to take the initiative to find the retarded child early in his school life, and to be the thorn, if need be, in some situations to bring about parent understanding of the kind of child they have. We should help them avoid making the child's life in school a miserable measuring up exercise in which he always falls short. I would go futher and suggest that we reach the parent when we learn of a deficient child who is not in school. I do not mean to suggest that the schools are indifferent, but that we need to be more aggressive in our work with parents who may not seek information.

HOW THE PARENT LOOKS AT MENTAL TESTING

Mrs. Everett Taylor

Mr. Chairman, fellow panel members, and all those who are present here today in the interest of mentally retarded children. When I was asked to appear on this panel, I confess it was with a great deal of hesitation and misgiving that I accepted. I hardly feel qualified to speak for myself, not to mention the many parents I represent who are so concerned about determining the capabilities of their child. However, I am a mother of a little girl who was diagnosed a mongoloid at birth.

Jane came to us nine years ago when our daughter Darleen was ten years and our son David was eight years old. The diagnosis given to us by our doctor was, "You have a mongoloid type idiot. She will never develop mentally or physically. Do not take her home. Place her in an institution as soon as possible." Needless to say a diagnosis and prognosis such as this came as a swift, hard blow and left my husband and I numb with little to do but follow the advice given to us.

She was placed in a boarding home to await the actual commitment proceedings necessary for State Guardianship and Institutionalization. The seven months which followed gave us opportunity to gather our wits and get a better description of mongolism, to discover also that there was a difference of opinion even among the medical profession as to the possible development of such a child. It was upon the advice of a pediatrician who said, "Yes, the baby has mongoloid characteristics, but I do not immediately advise that she be placed in an institution. Take her home and give her love, good food, especially proteins, meat, fish, eggs, cheese, etc." We took her home at seven months and have been engaged in discovering her capabilities ever since. This has been a real advanture for us.

It was a little over a year ago, while Jane was attending kindergarten and we were making plans for a special class in our district, that we had her tested by Dr. Harriet Blodgett at Sheltering Arms. The results of the test at that time showed she has an I.Q. of 49 which sometimes has been a controversial figure. This meant she was trainable but not quite ready for the educable group. Since the special class started in our school was a Group 1 and no Group 2 class was available the principal placed Jane in the regular first grade in the mornings and the special class in the afternoons. It did not take us long to realize that she could not cope with the situations in the first grade room so now she is just going to the special class two hours a day. She has progressed a great deal this year and is so happy to be able to ride on the school bus and associate with other children.

We were thankful for Dr. Blodgett's diagnosis and the help she gave us in knowing Jane's limitations and possibilities and planning future training. However, we feel that had we followed the original advice given to us, the door would have been closed to discover her capabilities.

This is the point that I believe parents are most concerned about. Every child born into this world has the right to his parents' love and the same opportunities to develop the abilities he has, even though limited. The attitude of many parents to their retarded child is influenced so much by the way in which they are informed of the results of a diagnostic test. When the future is not so bright they feel it is hopeless to try at all. Even with the progress made in the last few years in public acceptance through our parents groups, there are still parents today who are hiding the truth because of guilt and shame and are telling their friends the baby is dead, when actually he is in an institution. I believe doctors, psychologists and social workers can all help the parent to get away from that feeling by taking the time to talk the problem over carefully.

We want to be very sure that every area of a child's potentialities are explored in the testing program so that we can help them develop whatever abilities they do have, to the fullest. I discussed this topic with several parents, recently and I will try to bring to you some of the questions they had in mind. Why is it necessary to know the exact I.Q. of a child? Why can't the parents be with the child during the testing? Just how do you test a child's intelligence? Can you be very sure that the child will never go beyond a certain age level? The tests seem to show us all the things a child cannot accomplish, would it be possible through the test to find the things he can do or could be taught to do? We, as parents, have to be the ones who interpret the child's behavior and test results to our relatives and friends and the community. Would it be possible for the psychologists to spend more time explaining the results in a simple, kind, understanding way so that we could tell others more easily? This is so important to us in trying to determine the best place for our child, whether it be in the institution or in the home and in taking advantage of the services available in the community.

If all the parents could be present at an institute such as this and listen to the fine discussions we have had and know that each one of you are sincerely interested in the best possible diagnosis and training for their children, I am sure these questions would not be asked. Since that is impossible, it then seems to be up to you social workers to carry the message back to the parents and help them understand the testing program better. Those of us who have our children under State Guardianship appreciate the help you have given us, however, we do have times of despair and discouragement. A word of praise and encouragement, along with concrete suggestions in helping our child develop whatever capabilities he has, would be a great value too as you make your routine calls. Tell us about a new book, pamphlet or magazine article that would give us new insight into our problem or give us ideas for games, toys or activities that would be of benefit to our Jane of Johnny.

We parents too have a responsibility, for we are the ones that know our child better than anyone else and must make the decisions that will affect his future. There is much information available now to help us train our children in the home. Just get in touch with the local, state, or national parents association and they will be happy to help you. Let us work together to keep the door open to discover the capabilities of our children.

THE ROLE OF THE ASSOCIATIONS FOR RETARDED CHILDREN

Stanley Crist

The subject assigned to me, "The Role of the Associations for Retarded Children," (which I shall call ARCs) is so big and of such interest to me that were I to ad lib, I would be speaking the rest of the day. And so, to protect us all, I shall try to confine my remarks to the most significant roles as I have seen them, hence the notes.

There is no argument. The discovery that our child cannot grow like other children and fulfill our dreams for him is a shock and finds us overwhelmed by feelings of inadequacy, bitterness, bewilderment, anguish, envy, grief, and wonderings about what we may have done to cause or deserve this great burden.

But such suffering should not and need not be pointless. Philosophers through the ages have pointed this out and Pearl Buck, in telling the story of her retarded child says, "Sorrow fully accepted brings its own gifts. For there is alchemy in sorrow. It can be transmuted into wisdom, which, if it does not bring joy, can yet bring happiness."

The most significant role, then, of the ARC, as I view it, is to help parents discover the wisdom that rests with sorrow. To use Pearl Buck's figure of speech, the ARC can serve as the catalyst in this alchemy, to help parents recognize this truth and transform their seeming tragedy into constructive emotions and efforts to benefit themselves as well as society.

I look back to the days when my wife and I first came into the "brotherhood" of others facing similar problems. Like most, we had felt so alone with our problem and actually believed that no one ever before had faced a situation quite as tragic as ours. But once within the group, we learned that we were not alone and certainly ours was not the most tragic problem.

One mother summed up the transformation in her feelings by these words: "Here we belong because of and not in spite of having a retarded child."

Well, before we knew it, we were sharing our experiences with others and we recognized that we were not only receiving -- we were also giving and we recognized we were needed.

It is fascinating to watch parents grow in their maturity of outlook -- first in the interest in their own child and own problem; then in other families with a comparable problem; then in the many aspects of the total problem and finally a concern for all retarded children everywhere.

Not all parents seem to be able to make this steep ascent and some are very slow in accomplishing it, but gradually we are discovering some of the secrets of the alchemy so that we can apply the catalyst in a more-than-haphazard manner, although much remains to be learned of this process.

As an outgrowth of this all-encompassing role of ARC, we find it leading us into many interesting adventures and experiences. Often it uncovers our own hidden talents along with helping us to find real purpose and meaning in our own lives and the lives of our handicapped children.

One of the new experiences for me was to head up a fund raising campaign several years ago in our local community. I knew nothing about fund raising and until then had paid little attention to methods used by other organizations. This was a real eye-opener.

In trying to arrange publicity for the drive, I noted with envy how the March of Dimes had used a picture (in our local newspaper) of a local lad, still somewhat crippled with polio, carrying a story telling how the March of Dimes had helped him.

I couldn't help thinking, "How can a retarded child tell the story of what the ARCs are trying to do for him?" He can't. WE MUST SPEAK FOR HIM. So this becomes another important role of the ARCs.

Although the retarded have been with us since the beginning of mankind, it is only in the last decade that very many people have recognized the significance of the mentally retarded person in our human society. This understanding has spread as we parents have learned that the life of every child, even the retarded child, is important. It is a wondrous thing when we come to the realization that our child's life has purpose and meaning and we determine that we and our child shall make a contribution to society. Several books and many articles written by parents attest to the fact that this realization is a wondrous thing, as they have found themselves compelled to tell others via the printed word.

Far too long the mentally retarded have been treated as hush-hush; as something not quite respectable. Surely parents in the years past must assume their share of the blame for this attitude, but the blame is not all theirs.

Public response to the needs of the retarded, however, has been in direct proportion to the efforts of the parents to bring the problem out in the open and discuss it freely. That parents, working together through the ARCs, with the help of our professional friends, have been successful in telling the story of the retarded to the public, one has only to compare the magazines, newspapers, and books published today, to those of ten years ago. Mention of the retarded in national publications, on radio and TV, is quite common now.

These things don't "just happen" as I once thought, before learning, through necessity, something about publicity and public relations. Every time an article appears in a magazine, or a newspaper, or mention is made on radio or TV, somebody has been working and working hard, behind the scenes. Presently, those "somebodies" are usually working through an ARC.

Thus far, I have spoken of the roles which ARCs play largely for their own immediate benefit. There are other important roles performed in more direct cooperation with others.

Our relationship with the professional workers has an interesting background. Not always has the situation been as it is today. The fact that we parents are today participating with professional workers in this institute is very significant. Back in the days when "parent groups" were still just a local phenomenon and a national movement was but an idea, I have been told that certain members of the American Association on Mental Deficiency attempted to make the lay efforts subsidiary to the professional organization. On one occasion, I was told, a lay person was asked to speak before a regional group of professionals of this organization, but he was treated rather suspiciously. Fortunately, however, there have been enough broad-visioned professional workers (the finest of whom are right here in our state and in this room) to give us courage and support and guidance in going forth soundly and constructively as a lay movement. Now, and during several years past, the AAMD has had a Liaison Committee to cooperate with the ARCs and there has evolved a great spirit of cooperation on many fronts between the two organizations.

Time has demonstrated the wisdom of ours being a PARENT DOMINATED organization, and it must remain so. However, we have all learned that parents and professionals are not competitive in their efforts, but complementary and that we must all work together. We know that some ARCs, in their zeal for getting things done have set up professional advisory groups and have then failed to seek their advice. We hope we are growing past that stage of immaturity.

When we find differences of opinion, and there are differences, will always be differences, even among professional workers, we must strive to make these differences enrich, rather than impoverish us, in meeting the needs of the many people who are suffering, sometimes needlessly, over the problems presented by a mentally retarded child. We must learn how to work together, to supplement and augment the work of each other, for we are not mutually exclusive, but mutually dependent.

We are serving professional workers in ways which may not be apparent to the casual observer. Some have expressed their gratefulness to us for helping to make their jobs easier. Dr. Martha Eliot, former director of the US Childrens Bureau, in speaking before the NARC in Boston in 1954, said:

"When officials of public agencies ask what kinds of services should be provided for retarded children, my advice to them is to 'ask parents.' Parents who have lived and worked with retarded children are often best qualified to say what help they need, though professional persons will have to provide the hows. And if the public official does not ask, my advice to you is to speak up and tell him."

Well, we have spoken up, and when many little voices get blended together, it is quite apparent that we have been heard!

It is not strange that the ARCs have been a powerful force for good in our own country as well as over the face of the earth. Most of our professional workers now recognize the ARCs as an important resource and are working in partnership with us to better our organizations and to encourage parents to come to us for the help they can receive themselves, as well as the good they can do for others.

Parents do need skilled professional guidance. From personal experience, I know that there are many understanding, well-trained, kind, helpful professional workers who do wonders in helping parents over the rough spots and in brightening their outlook. In fact, if parents aren't getting that kind of help outside the ARCs, they may serve as parasites rather than constructive helpers within the association.

It's no secret. We have a long way to go to provide adequate professional counseling and guidance services to large numbers of parents; particularly in the rural areas. The cooperative efforts of parents, professional workers and administrators must be stepped up in our attempts to prevent as much damage as possible within these suffering families who do not have ready access to, or finances to seek out the help they need. Oftentimes, they don't even know they need help without being guided.

Another area in which great cooperation is going forth is in research, all kinds: social, educational and medical.

Pearl Buck pleads the case for medical research eloquently, in her book The Child Who Never Grew. She states: "Other ills have been cured and research is being carried on for those we still do not know how to heal. All must be healed, of course. People must not die of cancer or polio or heart disease. Neither should there be mentally deficient if it can be prevented or cured. There cannot be a choice of which will be first. The battle of life must be fought on all fronts at the same time."

"Therefore, I say, we must also fight for the right of our children to be born sound and whole. There must not be children who cannot grow. Year by year, their number must be decreased until preventable causes of mental deficiency are prevented. Our state institutions are dangerously overcrowded and unless research is hastened, millions of dollars must go into more institutions. How much wiser and more hopeful it would be to pay for scientific research which would make such care unnecessary!"

Dr. Richard Masland, research director of NARC, tells us that most research personnel just naturally work in those fields which are closest at hand, most convenient, and for which there is public support and interest.

Few professional workers, it has been said, have the drive to work in some of these areas until there is someone to clap for them, which is only human because we all like to have our work noticed and appreciated. But now there is not only an appreciative audience willing to support such research with a little urging, but a host of parents anxious to cooperate in any research that is done and standing ready to clap whole-heartedly for anyone who finds it possible to add and communicate any knowledge on the diverse subject of mental retardation.

Along with discussing what the role of the ARCs is or ought to be, I think it not amiss to mention what the role ought not to be.

In our efforts to have the retarded child given opportunities which are naturally assumed for non-handicapped children, many ARCs have had to operate and conduct their own classes. This is all right as a pilot operation, a demonstration project to show the needs and the desirability of giving these youngsters an opportunity to learn and some relief to parents while they are in the throes of some important decisions. But in no wise should it be assumed that it is the role of the ARCs to continue to carry this load. Just as quickly as possible, such operations should be assumed by the appropriate public agencies who have trained people for administering such programs.

There is no question that much of our parent talent has been, and is being dissipated away from our main purposes because we have had to fill the gaps left by educators, professional workers, or administrators. Not a few of our most demanding projects, unfortunately, fall into this category.

Another note of caution I feel is necessary. It must always be the role of the ARCs to work for ALL retarded children EVERYWHERE.

Gil Hanke, deceased past president of NARC, said, "We must remind parents that if they are concerned only about their own child, then their child will have only two friends: its mother and father. However, if each parent works in behalf of all retarded children, then his child will have the active friendship and help of all other parents and friends."

Likewise, we must never become an association interested only in the care of those in the homes, or one interested only in the care of those in the institutions. It is our role to promote the welfare of ALL retarded children EVERYWHERE.

Senator Jackson of the State of Washington, in addressing the 1956 convention of the NARC in Seattle, made this statement: "Your supreme achievement has been to help thousands of families translate their calamity into constructive care for individuals and social welfare."

In the years ahead, with your help, we hope to strive towards an even fuller achievement of that role.

I thank you.

NEEDS AND GOALS FOR THE MENTALLY RETARDED AS SEEN BY THE DEPARTMENT OF PUBLIC WELFARE

Morris Hursh

I am sorry that I have not had the advantage of attending all of the sessions of this Institute and hearing the discussions that you have had. Most of what I shall say has probably been covered in one way or another at one of the previous sessions, but I am glad to have the opportunity to speak to you and indicate what we in the Department consider as the needs for the mentally retarded and the goals that we are trying to meet.

In looking at some of our needs in this field let's start with those that could be taken care of by legislative action. Two of these are very simple: buildings and staff. There is need for increased appropriations for both. We have over one thousand persons on the waiting list for institutional placement and there is a waiting period of from two and one-half to three years before a child is entered in the institution after the need for this care has been indicated.

You might be interested in some statistics concerning the mentally deficient and epileptic who are under guardianship. There are at the present time about five thousand in our state institutions, divided approximately as follows:

Faribault State School and Hospital	3200
Cambridge State School and Hospital	1400
Owatonna State School	370
Lake Owasso Children's Home	85
Shakopee Home for Children	30
Annex for Defective Delinquents	75

It seems there are more problems connected with planning for the mentally deficient that cause pressure from legislators than with any other group. I have constant letters and calls from legislators asking for special consideration for a child whose parents are unable to keep him in their home and give him the care that he needs. This pressure for space exists in spite of the fact that we have 400 new beds at Cambridge and work has been started on buildings to provide for 500 more. A start was made on a new institution at Brainerd at the last session of the legislature. The Department requested that the present legislature provide for a thousand beds, but the building committee recommends that this be cut to 500 at a cost of $8,800,000. However, for probably the next five years the situation is not likely to be good, since even the beds at Cambridge which I mentioned will not be available for two or three years and every year we have a net gain of about 215 commitments to guardianship. Most of those placed under guardianship should have at least a period of institutional care.

The second of the needs which must be provided for by the legislature is that of additional staff. This is in very short supply. Under the Governor's recommended budget we will get a modest increase in staffing, but this is only about half of what we asked for, and in making our requests we had felt they were kept down to the minimum.

I now want to speak of the recommendations of the Legislative Interim Commission on Handicapped Children. The Commission has drawn several bills to be presented to the legislature. One of these is a mandatory bill to provide educational services to the educable retarded as well as to other handicapped children. There is a permissive bill offering state aid to schools who wish to provide classes for the trainable. This experiment in definitely providing education for both the educable and trainable involves some difficult problems in administration, although it is my feeling that state aid should be provided through the Education Department.

It has become apparent that the problems of providing for the mentally retarded are not going to be solved merely by building more and larger institutions and we don't think it should be. In trying to achieve our ultimate goal of helping every mentally retarded person make the best possible adjustment and realize his maximum potentials, we need to develop skills and resources which will enable more of the mentally retarded to be cared for outside of institutions. There are 6 points to be considered to accomplish this:

1. Encouraging further development of parent groups and similar organizations, which interpret the problem to the public and to families where there is a retarded member. Much has already been done in this area. We have had a committee working for sometime now composed of representatives from our Department - both central office staff and institutions serving the mentally retarded - county welfare boards and parents. They have produced some excellent pamphlets with which you are familiar and their work has brought about greater understanding of inter-related problems.

2. We are now recruiting for a social worker to be added to the staff of the Section for Mentally Deficient and Epileptic to serve as a consultant to local communities in developing their own resources. This worker will provide information and inspiration, offer consultation, and do a job of community organization with all types of local groups. This position will be financed with federal funds.

3. We are now trying to obtain some private Foundation funds to learn better methods of supervision of the higher grade mentally deficient person who presents personality problems. This project is to help those who have reached the age where they might become self-supporting.

4. We think there would be much to be gained by employment of a person (probably with federal funds) who would assist the counties in recruiting job placements for patients discharged from our institutions, both for the mentally ill and mentally retarded. He would work with industrial,

labor and farm groups, as well as with private agencies and individual employers - to help interpret the kinds of jobs such patients can handle. Our Department has had a very successful experience for many years in such a program for the blind. We haven't made much progress in getting this job started but hope it can be set up in the not too distant future.

5. There is great need for trained staff to work in the field of mental retardation both in our institutions and at the community level. In the field of social work there are few schools offereing specialized instruction with field experience. At the present time Peabody College in Nashville, Tennessee, has a federal grant for the purpose of training psychologists at the level of a Ph.D. to work with the mentally retarded. Because of this program the School of Social Work at the University of Tennessee (also located in Nashville) has become interested in trying to set up a course to give special training to social workers. These two institutions, with the addition of Vanderbilt University (also located in Nashville) have an agreement whereby a student registered in one of them can take work in any of the others. If their program for training social workers develops as it seems it will, it is hoped that some of our personnel can go there for training.

6. There is need for much more research. I do not know how hopeful scientists are in this area of research, but surely this must be one of the approaches we have to take in meeting our tremendous problem. In our hospitals we have a wealth of clinical material. Our Department is collaborating with the University of Minnesota now in a small research project involving patients at the Faribault State School and Hospital. The University has received a substantial grant from the National Institute of Mental Health for a research program. By its very nature research in this field must be on a long-time basis, but if we are ever to learn how to prevent retardation there must be continued emphasis on it.

We have cooperated in another field of research. Dight Institute, a part of the University, has made a study of a group of patients who were at the institution in Faribault some 40 years ago. They have followed the descendants of these patients and the results when published should be of great interest.

An impetus to the development of more research will be given by the legislature if it passes the proposed bill for payment by the families of those receiving institutional care. There are several provisions in this bill that are of interest. Parents will not have to pay for patients over 21 years of age and only parents, spouse or children will be asked to make a payment, if able to do so, for those who are younger. Furthermore, the maximum that any parent will pay will be 25 per cent of the institutional costs and this will be graduated for those who are able to pay less. Many will pay nothing at all. The interesting thing about the bill in relation to research, however, is that 40 per cent of the amount paid by relatives will be placed in a research fund. This provision is also included in the proposed charges bill for the mentally ill. This feature of the law will tend to make charges seem less unfair to those who feel that there should be no charge made.

These are some of the things we are planning and thinking about. But we have a long way to go. There must be thousands of mentally retarded in the state we haven't even heard of - but who need our help. To try and find them only increases the problems of our staff and those of the county welfare boards who are already overburdened, but I am sure you will agree that unless we offer our services to every mentally retarded person we are being unfair to some retarded persons and their families.

More and more the emphasis must be on greater service and more resources in the local communities, as I see it, even if that is where our state funds must be spent. We need clinics and treatment centers, sheltered workshops, camping and recreational facilities, day care centers, and more boarding care facilities. But above all we need public understanding and increasing cooperation between the state, the county welfare boards, parents, and the many groups concerned with the problem. Only when we establish this understanding and cooperation will we be able to attain the ultimate goal, which was so well stated by Miss Coakley in her talk at this institute: To give every mentally retarded person the maximum opportunity to enjoy the fullest life of which he is capable.

INSTITUTE ON MENTAL DEFICIENCY

Five workshops were held to explore the various aspects of preparation and placement of the mentally retarded person from the institution into the community, and supervision of him after placement.

The groups were organized as follows:

Workshop I

Leader: Robert Peterson, Case Worker, Section for Mentally Retarded and Epileptic, Hennepin County Welfare Board.

Resource People: William Keenan, Supervisor, Division of Vocational Rehabilitation.

Robert Boyer, Social Services Consultant, Division of Medical Services, Department of Public Welfare.

Caroline Perkins, Social Services, Faribault State School and Hospital.

Recorder: G. M. Elleson, Executive Secretary, Cass County Welfare Board.

Workshop II

Leader: Dagny Johnson, Unit Supervisor, Medical Division, Hennepin County Welfare Board.

Resource People: Unavailable

Recorder: Julia Zehnle, Case Worker, Child Welfare, Todd County Welfare Board.

Workshop III

Leader: Unavailable

Resource People: Mr. Schoppert, Division of Vocational Rehabilitation.

Laura Zemlin, Minneapolis Sheltered Workshop.

Francis Stevens, Child Care Supervisor, Owatonna State School.

Recorder: Aileen E. Fridner

Workshop IV

Leader: Unavailable

Resource People: Unavailable

Recorder: Susan Walker

Workshop V

Leader: Frances Coakley, Supervisor, Department of Welfare Services, Ramsey County Welfare Board.

Resource People: E. J. Engberg, M.D., Superintendent, Faribault State School and Hospital.

Mr. Kurlin, Division of Vocational Rehabilitation.

Recorder: Irene Dombovy, Case Worker, Benton County Welfare Board.

The findings of the five workshops are summarized under three major headings.

Preparation for Placement

Preparation for placement was recognized as primarily the responsibility of the institution. It is a process, however, in which the County Welfare Board needs to participate - a process, in fact, in which it could well play a larger part.

Comments and recommendations were as follows:

1. A big job of the institution is to develop the social maturity of the patient, as this is the most important basic factor in successful community living. Preparation must include training in habits of personal cleanliness, being on time, following instructions, honesty, dependability, ability to handle money, training in specific skills, if possible, and, above all, getting along with others.

2. Another big job of the institution is to help the patient gain insight into his condition and help him to be realistic about his abilities, limitations, and goals.

3. It was suggested that the institutions might set up artificial situations to illustrate job interviewing and other experiences the patient may encounter in the community.

4. A closer working relationship is needed between the county agency and the institution during the period of the patient's institutionalization, so that there is awareness of what the other is doing and a

better knowledge of the patient. Visits to the institutions by welfare boards and staffs will help to accomplish this.

5. Continued contact between the patient and his family should be fostered and encouraged as a help toward later placement.

6. Helpful methods of gradual preparation for re-establishing the patient back in the community are (a) vacations in the community (b) camping programs (c) "half-way" houses (d) boarding homes. (County agencies must be willing to provide adequate pay for such foster home care.) These methods will help the patient get used to living in the community without his needing to face the full pressure of such an adjustment all at once.

7. The Department of Vocational Rehabilitation can help in exploring the work and training potential of the patient.

8. Opportunity Workshops can explore capabilities in simple tasks which may sometimes open the way for further vocational rehabilitation. These facilities are being expanded.

9. The institution needs to furnish the county agency with adequate referrals of prospective placeable patients. Some things the county agency needs to know are: what the patient can do, in what situations he becomes frustrated, his physical limitations when a controlled setting is needed for living or working, etc. The county agency should then evaluate the patient's potential for placement in the light of what is available to him in the community.

Techniques of Placement

The goal held out for the ward must not be greater than his ability to accomplish. Success in the initial placement is extremely important, as the traumatic effect of failure may be disastrous.

Some techniques suggested to help insure success were as follows:

1. Recognize that the ward leaving the institution, particularly after a long stay, faces fears and frustrations; and a variety of new experiences that to us are simple and automatic (such as transportation, telephones, ordering meals in a restaurant, etc.). Remember - - you are working with a whole person.

2. Be sure the ward receives close supervision. He will need much support and encouragement. Be patient, understanding, not too rigid, not excited when the going is rough. Do not relinquish supervision until you know the ward is ready for it.

3. Let the ward adjust to his new home - then try a job. It is enough for him to have to adjust to one new situation at a time. On the other hand, don't wait so long to let him try a job that motivation is destroyed.

4. In contacting prospective employers, use the positive approach. Stress the ward's good points. On the other hand, do not oversell him. The employer has a right to expect performance equal to the wage paid. He wants the facts - and these should be given to him clearly and honestly. Continued counselling to the employer is needed to maintain his understanding of the limitations of the ward. The employer has a right to expect this service.

5. Failure of the initial placement, however, should not end the matter. Return to the institution for further training and counselling may result in success the next time. A ward may need to make several unsuccessful attempts at community living before he learns his limitations and can be realistic in his goals. A close working relationship is needed here between the agency and the institution. Less over-crowding of the institutions would provide much more flexibility in letting the ward move back and forth between the institutions and the community according to his special needs.

Finding of Placements

The finding of placements for living and jobs is primarily the responsiblity of the County Welfare Boards. Three of the major problems faced are an apparent lack of resources for placement and apparent lack of time to find resources, and the stigma the community places on mental retardation. Yet it was strongly felt that the community contains many hidden resources that can be developed.

Comments and recommendations were as follows:

1. One primary job of the county welfare agency is to know and coordinate resources.

2. Education of the community through all available means regarding unmet needs and its responsibility to help, would open up new resources. The stigma of retardation needs to be removed through enlightenment and understanding.

3. Important resources that could be further developed in the community include (a) parents groups (b) the churches (c) the schools (d) civic and fraternal groups (e) county nurses, etc. The could be used to help in the education process and provide volunteer services in resource finding activities. The Department of Public Welfare has a volunteer coordinator who is available to help with consultation in the organization of volunteer services. You have to get out and dig for job openings - the volunteers can give the time and the leg-work that the professional staff does not have the time for.

4. The ward's family could be a much greater resource for living and job opportunities if it was kept in close touch with the ward and participated in planning for his placement.

5. The Department of Vocational Rehabilitation is expanding its services for training and placement of the mentally retarded.

6. There is need for a better system of listing job openings. Jobs that wards can handle are often not listed with established agencies.

Three major premises kept recurring with increasing emphasis throughout the discussion of all five workshops. They were:

1. The job of placement opportunity for the mentally retarded is one that requires the utmost of teamwork between the patient, his family, the institutions, public and private social service agencies, and the community. The catalytic agent, particularly in rural settings, is the County Welfare Board.

2. The community must be informed. When it is informed it will understand. When it understands it will help meet the need with resources it never before recognized it had. The County Welfare Board, particularly in rural areas, is in an excellent position to help the community achieve fulfillment of one of its basic social purposes for existing.

3. There is a place in the community for every mentally retarded person who is trainable for self-care and/or educable for job performance - if that place can be found. The mentally retarded person has a basic right to this opportunity. Experience has shown that this goal is obtainable!