

June 29, 1960

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FROM: David J. Vail, M.D.
Acting Medical Director

SUBJECT: Attached Document on Institution Work Programs

I am enclosing for your consideration and study, and for the consideration of your staff, a number of copies of a document which I have recently compiled, dealing with Institution Work Programs.

This is another on the list of "Debatable Issues." Here again is the opportunity and the task of examining all the facets of this complicated subject. I hope that you will give it your earnest attention and respond either individually or collectively.

The document is divided into two parts. Portions of the preamble were originally written as preface to a mental health project grant application which I was unfortunately never able to develop fully, mainly as a result of the deep confusion which I have felt about this problem, confusion which I have never been able satisfactorily to resolve in my own mind. In the interests of provocation, it is deliberately stated in somewhat radical terms. Section II includes what seem to me some of the important questions which must be dealt with.

I am looking forward to an interesting discussion on these issues at our next regular meeting.

DJV/kg
cc: Medical Division Staff

AN EVALUATION OF INSTITUTIONAL WORK PROGRAMS

I. Preamble

How appropriate are institutional industrial therapy programs to the realities of finding and maintaining extramural occupation? This question is still largely unanswered. Industrial therapy in the institution has developed traditionally ex post facto, as an effort to dignify the condition of the institution work patient and to create on an individual prescription basis a genuinely therapeutic and self-fulfilling occupational experience which could carry over directly or indirectly as a beneficial preparation for post-hospital life.

The moral basis for industrial therapy in our time, as these programs exist generally in institutions for the mentally ill and mentally retarded, is not only weak but possibly entirely false. Strong question can and should be raised as to whether these programs are related to anything that is really "industrial" or even "industrious" according to twentieth-century standards, or whether they are indeed actually therapeutic.

Current practices are based on two elements: (1) the fact that public mental hospitals depend on patient labor for their very survival, particularly in laundry, food preparation, agricultural and nursing-care areas, and (2) history and logic. The necessity for patient labor is acknowledged and hardly debatable under existing staffing conditions, but it is dealt with by an uneasy process of moral doublethink. This moral problem is dealt with at some length below.

The second element, history and logic, is more fundamental. The basic premise involved is: Idleness is bad. This is a truism that can be easily substantiated not only by ordinary experience, but by studies of brainwashing techniques and experiments in sensory deprivation. From the basic premise that idleness is harmful comes the corollary, Work is beneficial. From this, all too easily in our public mental hospital situations, comes the sub-corollary, Any work is beneficial. The historical tradition goes back at least as far as the early roots of the Reformation and specifically Calvinism, with its stipulation that Grace is manifested by success in the present world, and is manifested, if not actually achieved, by the capacity for work. This tradition can be traced down in a direct line through the Puritan movement of the seventeenth century English middle class which is still detectable as the backbone of American culture. It is this basically religious tradition which is seen in the moral aspects of the idleness-work problem, and exemplified by the honored proverb, "The Devil makes work for idle hands."

The ugly term "slave labor" is often heard with respect to institutional industrial programs. While there is no purpose to be served in considering this in any detail, it is interesting to note that rationalizations in favor of industrial programs for the custodial patient on the one hand and arguments of a century ago supporting the "peculiar institution" of slavery in southern regions of our country are surprisingly similar at many points. The position is as follows: "These are individuals who are fundamentally incapable of producing competitively in the open market. We protect them from the stresses of the world. We provide for their needs and take good care of them. By keeping them busy we ensure not only that they will keep out of mischief but also that they will achieve some measure of personal satisfaction in useful work. At the same time they help us produce. We help them and they help us."

Is any work implicitly beneficial? Institutional programs tend to be geared to antiquated procedures, employing manpower on a mass basis under conditions of inefficient methods and flimsy motivations, often with the assistance of obsolete equipment. A simple illustration of this problem is provided in the example of institution farm programs: individuals accustomed to a decade of hand-wicking crops where there is no premium on

efficiency are completely at a loss to adjust to modern agricultural operations which demand not only attention and perseverance on the job but the ability to manipulate increasingly complex machinery.

There are deeper implications beyond the mechanical. An effective industrial therapy program, regardless of its capacity to develop specific skills or to "teach a trade," should be oriented to two main tasks:

- (1) development of effective work habits and attitudes, and
- (2) development of the capacity for making decisions

There are two further goals which relate to the general context of rehabilitative therapies. These are:

- (3) nurturing of a sense of social responsibility and the capacity of improved social relationships, and
- (4) the cultivation and enjoyment of leisure

Deep and searching study is indicated to determine whether "industrial therapy" as we now understand it provides any of these things. I am prepared to defend the thesis that it does not.

We assume that the test of an effective industrial therapy program will be the extent to which individuals who have "graduated" from it are able to hold their own competitively in the complex society which exists outside of public institutions. Even where the individual is, however, unable for more general psychiatric reasons to reach this goal and we must assume that he will remain in hospital, it is believed that the above considerations are still pertinent. The test in this instance would be to ensure that, although the patient is still "in institution" he is nevertheless not "institutionalized." There would appear to be little question that dignified citizenship in the institutional society is just as honorable and desirable a goal for many patients as the return to productive extramural capacity is for many others. The above general principles still apply. The difficulty is that in practical terms the task becomes morally more difficult; it becomes harder to ensure that we are not in fact perpetrating a "peculiar institution," harder to maintain ease of conscience in satisfaction that the work assignment is primarily for the patient's benefit and not the state's, harder to be certain that the work assignment is one which will in fact tend to increase human dignity.

Maintaining a status quo of the human condition is not enough—anything less is a blasphemy.

II. Questions

(It should be emphasized here that there is no intent to arrive at "uniformity." Rather these are viewed as a medium for discussion of the pertinent issues.)

1. What are the factors of a given work situation which make it therapeutic?
2. Assuming that therapeutic goals can be expected to vary (i.e., return to the community as against useful hospital citizenship) is there a corresponding difference in critical therapeutic factors or the therapeutic "set" of the work situation?
3. What are appropriate hospital work areas where participation is in actual fact "therapeutic?"
4. Are the basic goals different among mentally ill as against mentally retarded patients?
5. Is the concept of "industrial therapy" feasible as regards geriatric patients? What modifications in goals and techniques would be realistic?
6. Should patients be paid? How much?
7. Are there adequate safeguards against exploitation either in or out of the hospital?
8. Are industrial programs geared to the half-way house concept, or patient-employee programs (similar to those in R.I., VA., etc.) feasible in Minnesota?