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PRESENTATION TO THE 1964 CONVENTION OF THE MINNESOTA ASSOCIATION FOR RETARDED CHILDREN

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"HAS THE ROLE OF OUR STATE INSTITUTIONS CHANGED?"

In recent years, we have been seeing major changes in services for the mentally retarded. The focus of most of these changes has been the community; however, more recently, the institution has become more involved.

These changes, both in philosophy and actual programs, have been nationwide. We are seeing them here in Minnesota. Some of our ideas here are new. Many of our ideas are a reflection of events and ideas throughout the country.

Since I am talking today about our institutions for the mentally retarded and their role, I would like to first relate to you some of the very early ideas regarding care in these facilities.

In 1886, Dr. Arthur C. Rogers, superintendent of the Faribault State School and Hospital, a man who was highly regarded as a national leader in the field of mental retardation, listed these objectives of an institution: to provide comfort and care for the helpless. . . and schooling and training for both those able to return to the community and those who would remain and work in the institution.

Much later, the 1952 annual report of the Minnesota Department of Public Welfare, stated, "The Department seeks to individualize the problem so that the plan chosen best fits each child or adult's needs, thus providing the type of care most suitable to the individual. The objective: a favorable environment for the development of the mentally retarded . . . to the limit of his physical and mental abilities . . . at the same time making his life as happy as possible."

The 1956 Minnesota Mental Health Survey recognized the varied needs of the retarded with this statement, "The purposes of the state schools have been to provide care, training, education and treatment and to provide opportunity for maximum development in all these areas, either in preparation for return to the community or as the basis for as happy and useful life as possible within the institution."

The 1959 Mental Retardation Manual of the Department of Public Welfare has a section on individualization, as follows: "Individualization is the key principle in case work with the mentally retarded . . . guardianship will be exercised differently for different wards and for the same ward at different periods in his life. It will depend on such factors as age, mental level, physical condition, emotional stability, and the amount of care needed; the extent to which the family is able to understand and provide for him, the degree of community acceptance of him, the responsibilities he is expected to assume and his own aspirations."

I mention these things as background to show that the very early pioneers in this field, as well as people more recently, recognized that the retarded are individuals who must be planned for in different ways. Individualization of program or treatment is not a new idea.

Has the role of our institutions changed? I think that the previous comments reflect that it really hasn't very much. The institution leaders and superintendents have known what they wanted to do but in all too many cases have not been able to do it because of inadequate funds. The services they have been able to provide are often inadequate. There are other services they would like to provide but have not been able to provide at all. Primarily, the lack of funds is due to the lacks of citizen interest and finances from tax funds.

Another factor to consider regarding the role of our institutions is their size. We have recently heard many people advocate that we should have a number of small units scattered around the state so that the retarded can be closer to their homes. Certainly, being close to their home and family is a very worthy objective. However, the critics of the large institutions, who are usually the advocates of the small institutions, have,I think overlooked the fact that the large institutions have never really been given a chance to fully show what they can do. I would like to quote from a presentation by Harvey L. Smith, professor of sociology at the University of North Carolina. This was in a talk which he gave at the 15th Annual Mental Hospital Institute. He said, "Although the large hospitals are pointed to as the devils of the present situation, this may be more name calling than an established fact. Size alone may be less to blame than inadequate supports. Indeed, if we dare become experimental and venturesome, largeness may have some advantages. The fact that the large institutions approximate communities rather than true hospitals, for example, may prove beneficial if we use these communities to provide patients with re-training for occupational and social living. Clearly, they comprise a complex and varied society in which patients may learn to play many roles. This is in marked contrast to the social roles available to patients of smaller hospitals, which may well be limited to the sick or patient role. Occupational therapy and recreational therapy in a smaller hospital are usually artificial and irrelevant to the patient's real needs and desires. A large hospital can offer real trials at real work."

We are seeing a reflection of this in our Minnesota institutions for the retarded in that several have set up specialized units. All of the institutions have, or are planning, for instance, independent living units, where patients who are thought ready for discharge can be given a good deal more independence. I think we will always have our state institutions for the retarded and, for the most part around the country, they will be of the large type, although some smaller ones might very well be developed.

In looking back at our state institutions, I think we will see that overall they have been the most reliable service for those who need residential care.

What I am trying to do today is answer some questions regarding the function and role of our institutions, and also answer some of the questions that have been asked of me. One of the questions that I probably hear most often has to do with admissions--such as, why is it so difficult or, in some cases, impossible to get someone into a state institution? In order to understand this problem, I think that here also we need to look back aways.

In 1954, ten years ago, there were 4,892 patients in state institutions for the mentally retarded. There were 636 on the waiting list. Today, there are 5,980 in residence and 757 on the waiting list. As our population has increased, the number needing residential care has also increased.

In 1955, we saw an expansion of both Cambridge and Faribault to accommodate additional patients, and the beginning of construction of the Brainerd State School and Hospital. These measures have accommodated additional patients and Brainerd, of course, will continue to grow and will take more in the future. During this same period, the institutions for the mentally ill have decreased in size by approximately 4,000 patients. Here we have been dealing with a different problem in that therapeutic drugs have made patients manageable and made treatment possible. There is no such panacea in the area of mental retardation. . . at least, not as yet. So we do have an increasing demand for institutional space. Another factor which affects this is the reduction of the population of the Faribault, Cambridge, and Owatonna State Schools and Hospitals. An effort is being made to reduce overcrowding and improve the staffing ratio. We have long objected to overcrowding and understaffing, however, care must be taken if we do reduce institution capacity in light of the long waiting list. It is important that these reductions be carefully made.

Reductions in available space certainly cannot be made -- and have not been made-- without an effect on parents who are seeking placement for their child.

We are also told that only emergency placements are being made in our state institutions; therefore, parents who have been expecting placement after two or three year waiting periods are puzzled when space is not available. It would seem it would be important to make some kind of arrangement or plan so that we could recognize those who might need placement early enough to avoid a family crisis and to set a family crisis or emergency as a basis for admission.

Relating to the institution's role is the use of state guardianship. There have been questions, such as "Will guardianship be eliminated?", "Is it necessary for institutional placement. . . should it be changed. . . will patients be admitted without guardianship?" We have learned that a few patients, primarily higher level retarded, have been admitted on a voluntary basis. ... very often, for evaluation and diagnostic purposes. Guardianship, as far as we know, is still used on the same basis as before, and is practically a requirement for admission. It has been our feeling that it has functioned well and although changes are needed, the guardianship plan gives certain protection to the mentally retarded at the time of commitment to protect his civil rights and relative assurance that he needs such guardianship protection. We feel that the role of the Commissioner of Welfare as guardian has been very important. A number of states have been looking at our guardianship plan and thinking of adopting something along the same lines. Several committees, including one of the Minnesota Associations, are studying guardianship. The recommendations which will probably be made will deal with more careful procedures for court commitment, especially in the less populated smaller counties of the state.

Another area of discussion and I think, confusion has been the discharge and release of patients from our state institutions. I think the people who have in the past felt that the institution was a permanent lifetime placement for all retarded have been wrong. However, I think the people who have regarded the institution as a permanent placement for many have done so in good conscience and rightly so. We are now finding that many more retarded are being discharged from institutions. . . many to various types of community facilities. Between July 1, of 1961 and June 30, 1962, there were 156 patients discharged from the institutions, whereas for the same period 1962 to 1963, there were 308. Many of those being discharged are placed in nursing homes, boarding homes, and the group homes. For many, this may be the right thing. However, I believe there is a need to carefully evaluate such placements. Placement out of an overcrowded state operated institution to an inadequate, overcrowded community facility will accomplish very little, if anything. I do not feel that we are fully aware of the effect of such placements or that they are all as carefully considered as they should be. At the present time, there is a tendency to regard any community placement as better than a state institution because of the size difference. I cannot agree with this feeling.

There has been a fairly rapid development of community facilities, such as day activity centers. These, however, will never be a substitute for residential care for those who need residential care. The community facilities will, in certain cases, make it possible to keep some retarded children in the home for a longer period of time.

Now as you can see, I have raised a number of questions and I hope that I have given at least a few answers. Some of my recommendations would be as follows. First, there is a need for a much larger State Department of Welfare staff to screen placements and dischargees. The present staff is about one-half as large as needed. Second, if we are going to rely heavily on community residential facilities, the State must provide for more staff to license and examine them. We must also be sure that there are necessary and essential additional services, such as medical, educational, recreation, and religious training in connection with community residential services. Third, the parents' wishes should be the final authority regarding release from state institutions; also, the parents' role and decision must be more carefully considered upon admission. Four, our state institutions need to be improved greatly. We need also to study the future total need for institution space.

We are in a period of great confusion. The questions that are confusing parents, the questions that are being raised by parents, are the questions that people on our Minnesota Association committees are also raising.

I hope that my brief remarks today have not confused you more. I do feel we need to be aware of and try to deal with these very real problems.