

INSTITUTE ON MENTAL DEFICIENCY

October 26, 27, and 28, 1950

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University of Minnesota
Center for Continuation Study
Minneapolis, Minnesota

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UNIVERSITY OF MINNESOTA
Center for Continuation Study
Minneapolis 14

Institute on Mental Deficiency

October 26, 27, and 28, 1950

Program

Theme: What Can Be Done For the Mentally Deficient in Minnesota

Thursday, October 26

- 8:00 - 9:00 Complete registration. Dormitory Desk, Center for Continuation Study
- Presiding: Carl J. Jackson
- 9:00 - 9:15 Introduction Fred E. Berger, Carl J. Jackson
- 9:15 - 9:55 Goals (of parents, teachers, social workers, institutions, etc.) for the mentally deficient Harold A. Delp
- 9:55 - 10:10 Educational provisions and possibilities Mayme Schow
- 10:10 - 10:25 Discussion
- 10:35 - 11:20 The use of psychology in understanding the mentally deficient Harriett Blodgett
- Discussion
- 11:20 - 11:45 The social worker in the mental health program Marjorie Teslow
- Discussion
- 12:00 - 1:00 Luncheon. Center dining room
- 1:00 - 4:00 Who should be committed as mentally deficient
- Panel discussions
- Moderator Mildred Thomson
- Participants:
- County attorney John P. Frank
- Probate judge J. K. Underhill
- Psychiatrist David Thorsen
- Psychologist John Pearson
- Educator Lettisha Henderson
- Staff member urban welfare board Catherine Relf
- Staff member rural welfare board Irene Jacobson
- Social worker Bureau for Mentally Deficient .. Frances Coakley
- 1:00 - 1:45 Cases relating to children
- 1:45 - 2:15 General discussion of cases presented
- 2:30 - 3:15 Cases relating to adults
- 3:15 - 3:45 General discussion
- 3:45 - 3:55 Summary of two panel discussions
- 4:00 Tea. Center lounge
- 8:00 - 9:00 Forty-year follow-up of the mentally deficient (Museum of Natural History) S. C. Reed

Friday, October 27

- Presiding: Hazel C. Daniels
- 9:00 - 10:35 The place of institutions in a program of care and training
- 9:00 - 9:45 Film showing mentally deficient and epileptic persons
- 9:45 - 10:10 Minnesota School and Colony E. J. Engberg
- Discussion
- 10:10 - 10:35 Cambridge State School and Hospital ... R. J. Gully
- Discussion

- 10:45 - 11:45 The place of the low grade child in a program
for the mentally deficient Barbara Kohlsaat
Discussion
- 12:00 - 1:00 Luncheon. Center dining room
- Presiding: Fern Chase
- 1:00 - 2:00 The place of institutions in a program of training and care
1:00 - 1:30 Owatonna State School C. M. Henderson
Discussion
1:30 - 2:00 Annex for defective delinquents ... Ralph Rosenberger
Discussion
- 2:00 - 3:00 Guardianship as the basis for community
supervision Phyllis Mickelson
Discussion
- 3:15 - 4:15 A follow-up of placements from the
institutions Frances Coakley
Discussion

Saturday, October 28

- Presiding: Mildred Thomson
- 9:00 - 10:00 Trends in the treatment, care, training and
understanding of the mentally deficient Richard Hungerford
- 10:00 - 11:00 Discussion of paper and summary of the content
of the total institute program

Faculty

- FRED E. BERGER, Program Director, Center for Continuation Study, University of
Minnesota
- HARRIETT BLODGETT, Instructor, Institute of Child Welfare, University of Minnesota
- FERN CHASE, Assistant to Director of Field Services, Minnesota Division of Social
Welfare, St. Paul
- FRANCES COAKLEY, Social Worker, Bureau for Mentally Deficient and Epileptic,
Division of Public Institutions, St. Paul
- HAZEL C. DANIELS, Executive Assistant to Director of Public Institutions, St. Paul
- HAROLD A. DELP, Director of Child Study Center and Assistant Professor, College of
Education, University of Minnesota
- E. J. ENGBERG, Superintendent, Minnesota School and Colony, Faribault
- JOHN P. FRANK, Ramsey County Attorney, St. Paul
- R. J. GULLY, Superintendent, Cambridge State School and Hospital, Cambridge
- C. M. HENDERSON, Superintendent, Owatonna State School, Owatonna
- LETTISHA HENDERSON, Principal, Girls Occupational School, St. Paul
- RICHARD HUNGERFORD, Head, Bureau for Children with Retarded Mental Development,
New York City; and President, American Association on Mental
Deficiency -
- CARL J. JACKSON, Director, Minnesota Division of Public Institutions, St. Paul

Mental Deficiency

- IRENE JACOBSON, Executive Secretary, Sibley County Welfare Board, Gaylord
- NORMAN JOHNSON, Director, Center for Continuation Study, University of Minnesota
- BARBARA KOHLSAAT, Psychiatric Worker, Rochester Mental Health Clinic, Rochester
- PHYLLIS MICKELSON, Social Worker, Bureau for Mentally Deficient and Epileptic,
Division of Public Institutions, St. Paul
- J. M. NOLTE, Dean of University Extension, University of Minnesota
- JOHN PEARSON, Clinical Psychologist and Head of Bureau of Psychological Services,
Mental Health Unit, Division of Public Institutions, St. Paul
- S. C. REED, Associate Professor of Zoology and Director, Dight Institute,
University of Minnesota
- CATHERINE RELF, Supervisor, Unit for Mentally Deficient and Epileptic, Ramsey
County Welfare Board, St. Paul
- RALPH ROSENBERGER, Training Director, Annex for Defective Delinquents and St. Cloud
Reformatory, St. Cloud
- MAYME SCHOW, Supervisor, Handicapped Children, Minnesota Department of Education,
St. Paul
- MARJORIE TESLOW, Supervisor of Psychiatric Social Workers, Mental Health Unit,
Division of Public Institutions, St. Paul
- MILDRED THOMSON, Head, Bureau for Mentally Deficient, Division of Public
Institutions, St. Paul
- DAVID THORSEN, M. D., St. Paul
- J. K. UNDERHILL, Probate Judge, St. Louis County, Duluth

GOALS FOR THE MENTALLY DEFICIENT

Harold A. Delp

Every child deserves an opportunity to achieve his maximum of well-rounded growth and development. In order to achieve this maximum growth and development, training of all kinds must be adapted to his particular needs and abilities. The proper selection of the appropriate (1) time, (2) materials, (3) quantity, (4) speed, and (5) methods to be used in the deficient child's training must be considered to gain the best for his future behavior in all areas.

Dr. Elise Martens, of the U.S. Office of Education, has quoted a threefold challenge to parents, teachers, and others working with the mentally deficient:

1. to see that all possible obstacles to each child's maximum growth are removed,
2. to see that every child has a chance to reach the heights of achievement, and
3. to see that no child is forced into channels of activity unsuited to his particular type and level of ability.

In general, goals for the deficient are the same as for all children. However, there are some aspects which, while desirable for all, become necessities for the best interests of the mentally handicapped. Some of these are listed, including goals directly for the deficient child and for those working with him.

Goals for the mentally deficient child:

1. Correct diagnosis: An initial, paramount consideration. Professional help in which there is confidence.
2. Complete understanding - of the type and level of this child. Understand the physical situation, including any specific problems such as brain injury, loss of hearing, or other defect. Realize the training aspects and need for concrete training, in simple elements. Other factors such as short attention span and lack of power to generalize must be considered. The 10-year-old with the mental age score of 5 years is not like the average 5-year-old child. Realize that true deficiency is not correctable.
3. Complete acceptance of each child as he is. Acceptance of reality - by parents family, community. Old saying, "If at first you don't succeed, try, try again", not entirely correct and must be used with caution. All must learn to accept true facts. Build from here for child's best training.
4. Opportunity for the most satisfactory maturation. The best maturation for the child will be much slower than normal, but it still must have an adequate opportunity. The child must be given experiences, but they must be more simple, gradual, and specific. Actual experiences are most important because the deficient cannot generalize.
5. Removal of physical defects and development of maximum physical well-being. Make the child better able to get the most out of all training. Make him less noticeable and more acceptable by other people. One obvious defect calls attention to the person and then others are more apt to be observed. Healthy child is better able to cope with problems.
6. Development of desirable and healthful habits of living. Cleanliness, self-care. Accuracy, persistency, efficiency, courtesy, cooperation. Honesty, kindness, truthfulness, moral standards.
7. Gain of the best possible social adjustment. Learn to live and work with others. Learn to minimize comments by others about himself. Accept society as it is, and find his best place in it. Adjustment of wants to rights of others.

8. Acquisition of the most adequate personality possible. Includes best emotional adjustment. The deficient is more apt to encounter frustration and conflict; attempt should be made to keep these at a minimum. At least all efforts should help build a tolerance to such problems. Treatment by family and others usually toward an extreme - too severe or too lenient. Development should proceed to obtain feelings of independence and responsibility in proportion to total developmental level. Feelings of security and personal worth are difficult to obtain and require special effort.

9. Learning of fundamentals of academic education needed for use in life. This includes reading, writing, spelling, arithmetic, etc. which would be useful in making job applications, in carrying on simple job functions, filling orders, keeping personal finances, reading everyday signs, and the like. Training, of course, must be consistent with the mental level. All must produce a satisfaction of achievement - i.e., all work must be meaningful to the child, within his capacity to achieve, and such that a sense of accomplishment results.

10. Development of a fund of useful, workable information. To be adequate, this must be definitely related to the child's experiences. Include not only facts for daily use, but also principles of citizenship. Within limits, must develop information on living in the home, on a job, and in the community.

11. Day-to-day standards suitable to the child's level. Neither too high nor too low. Future needs are too abstract for the deficient to comprehend. He must understand present requirements and by habit develop actions to care for future problems.

12. Preparation for self-care. The amount of self-care depends on the degree of deficiency. This may approach partial or even full self-support as an adult. Must include not only self-care in a personal, physical sense, but also in terms of doing his share of other activities in the home or institution or on a job. The deficient must learn good attitudes toward work, employer, etc. He must develop habits of industry. He must be equipped as much as possible with specific skills of a work or vocational type, for home or outside.

13. Provision for simple, wholesome leisure-time activities. The mentally deficient must develop an interest in recreation, including both inside and outside activities. He must be taught simple games which do not require much mental action. If possible, he should develop some simple hobby. Training should include music and art for appreciation (and for participation if he seems to have any particular interest or talent).

14. Adequate supervision and guidance. This must include help for the child himself and for those working with the child. The child is more apt to make mistakes in all areas of behavior - because he has lower comprehension and because he is apt to be easily led by others. Parents and persons working with the child usually need frequent help. In general they do not have the technical knowledge necessary for best training the child. Also, their own problems and emotions are often involved; it is difficult for them to be objective with the defective child.

15. Adequate placement for the best advantage of all concerned. Placement for care - home, boarding arrangement, private or public institution. Placement for training - home, visiting teacher, special class, regular class, private or public institutional school. The child, the family, the community - all must be considered in making a final decision.

Agencies' goals for the child and to give maximum help to the child:

HOME Acceptance by the family of the deficient child as he is - without feelings of stigma, guilt, etc. The child is a "mental cripple". Help the

child live with his handicap, to attain the greatest degree of happiness and success for himself. He must gain a feeling of belonging. Develop self-care and, if possible, a degree of self-support as an adult. Assist the child in building appropriate attitudes toward himself and the world in general.

EDUCATIONAL

Facilities, trained teachers and other personnel adequate for diagnosis and for teaching the deficient child. Educate him at level of his abilities and by methods fitted to needs. Train him to make the most use of what he can do, and to minimize what he cannot do. Train in physical, social, emotional and mental behavior.

MEDICAL

Complete and adequate diagnosis. Correct all possible defects, so that best adjustment is possible. Because he is more susceptible to illness, better health supervision. Improve speech, motor coordination, etc.

COMMUNITY

Facilities available for adequate "Education", "Health", "Vocation", and "Recreation". Jobs available, suitable to his needs. Train the individual as a participating member of the community - at the individual's level of performance. Educate community as to proper attitudes toward him and the proper demands to be placed on him. Train their behavior towards the deficient.

INSTITUTION

Maximum self-care, and help for others. Educational skills and vocational training within institution. Maximum care of the individual, physically and otherwise. A satisfying, happy life in living with others - Physical social, emotional and work adjustment up to individual's capacity.

SOCIAL

"Maximum assistance to the individual and his family as needed." Supervision of the deficient in the family and community - home training, community relationships, adjustment in general. Give direct guidance to family on home problems, proper placement for care and training. Responsible for obtaining, distributing, and interpreting information and test data in terms of the individual concerned. Develop the maximum coordination of available agencies. Explain state program to family and community, including respective responsibilities. Prevent social problems through adequate planning with the deficient, the family and pertinent agencies. Assist in employment contacts working toward self support, full or partial, if possible.

THE SPECIAL EDUCATION PROGRAM FOR MENTALLY RETARDED CHILDREN IN MINNESOTA

Mayme J. Schow

Introduction

Special Education for Handicapped Children in Minnesota is now an accepted part of our school program. Provision for this service had its inception in 1915 when the State Legislature encouraged the establishment of special classes for handicapped children by granting fixed amounts of state aid to school districts for children receiving instruction under teachers trained for the specific handicaps of the children enrolled in these classes. The present program embraces classes for the blind and sight-saving, the crippled, and deaf and hard-of-hearing, the mentally retarded and speech defectives.

Philosophy

The underlying philosophy in educating the handicapped children in the public schools in Minnesota is expressed as follows:

Recognizing that children are the greatest of the world's resources and that these children although handicapped have in most cases far more ability than disability, Minnesota has gone all-out to provide educational opportunities for this group.

The goals of education for handicapped children are the same as those for all children. The difference lies in the means or techniques by which those goals can be realized and in a way in which they find expression in the individual's life.

The program is designed with full recognition of the pupil's likeness to normal children and his special needs.

The instruction is based on the direction of learning by use of individual instruction.

Referral of pupils for special educational services is made after adequate diagnosis of the physical and mental condition by specialists in these fields.

When possible, handicapped children should be programmed with children in the regular grades for some of their activities as this seems to offer the best means of social development for such children.

When children are so severely handicapped wither mentally or physically that it is advisable to segregate them both for their own good and for the welfare of other children, this should be done.

Program

The Legislature has from time to time indicated its unqualified approval of the care and education of these unfortunate children by broadening the provision for their training and increasing the amount of state aid as the need has been shown. The 1949 Legislature proved beyond a doubt its sincere interest in the humanitarian side of child training by passing Special Education laws and making generous appropriations for this service. As a result of the work of the Legislature in 1949, the amount of state aid of \$1.00 per child enrolled in a special class for the mentally retarded, was increased to \$150 per pupil. For mentally retarded pupils who have a multiple handicap, the aid may be paid on the basis of crippled, deaf or blind under regulations established by the State Board of Education.

The Annual Report for the 1949-50 school year shows that Minnesota has the following 22 centers for teaching mentally retarded children with 125 trained teachers in charge and a total enrollment of 2,090 pupils:

Albert Lea	Coleraine	Moorhead	St. Paul
Alexandria	Duluth	New Ulm	South St. Paul
Austin	Hibbing	Owatonna	Virginia
Brainerd	Little Falls	Red Wing	Winona
Chisholm	Mankato	Rochester	
Cloquet	Minneapolis	St. Cloud	

The cost of last year's program was \$553,261.36; the state aid paid out for this service was \$230,102.06.

According to the estimate of the U. S. Children's Bureau, there are approximately 9,000 children in the state in need of this special service. At the present time we are educating only about a fourth of the number entitled to this service.

Types of Services

1. One room in neighborhood school

Minimum of five pupils and the maximum of 15 pupils. Children are permitted to participate with children in the regular school in any type of school activity where possible.

2. Primary, intermediate and upper grades

In this type of setup, the minimum enrollment is 5 pupils and the maximum is 18 pupils. The same plan for having children participate with normal children is followed here also.

3. Schools for the Mentally Retarded

4. Junior High School

Coaching Class.....the teacher coaches the children in their work in regular junior high school classes.
Adjustment classes..teacher spends part of the day in a division of the Junior High School for mentally retarded pupils and part of the time with normal pupils. The state aid is pro-rated on the time spent with mentally retarded pupils.

5. High School

Pupil spends half-time with teachers trained for the mentally retarded and half-time in the shop where they are learning a trade.

Procedure for Enrollment

- Application
- Enrollment Card
- Teacher Record Card
- Program of Studies Report
- List of Pupils Enrolled in Class
- Annual Report

Future Possibilities

1. Flexible program
2. More trained teachers
3. Orientation courses in colleges
4. Acceptance of program by regular teachers
5. Reorganization of school districts will provide more centers

Education in the Mental Health Program - In view of the growing interest in the Governor's Mental Health Program, and because its implementation affects several aspects of the present and future services of the Department of Education, Commissioner Schweickhard discussed the requirements pertaining to the enrollment of mentally retarded children in special classes; namely, that at present the state reimbursement to public school districts may be granted only for educable pupils whose intelligence quotients fall between 50 and 80.

The Commissioner stated that according to the tests, a child with an I.Q. below 50 has been considered uneducable, and a child with an I.Q. of 80 to 90 has been classed as a slow learner. In the last few years, however, there appears to have been a changing conception with reference to the learning ability of the lower I.Q. group. It is now held by authorities that any individual is capable of learning something through careful training, even if it is only that of feeding and dressing himself.

The Commissioner said that he and members of the department had discussed with Dr. Ralph Rossen and members of the Governor's Mental Health Committee the advisability of breaking away from the established dividing lines in intelligence quotients, as it has been demonstrated that present I.Q. measurements are not always reliable. Examiners are accepting the fact that a child's intelligence quotient depends not alone upon the mental test which is given him but upon his condition at the time of taking the test. If a child is emotionally disturbed, fearful, resentful or angry, the results of the test will not be accurate; whereas, the same test given under more favorable conditions may place the child in a higher I.Q. group than the first test would have done.

The suggestion has been made to the Governor and his committee that the Department of Education undertake the education of the mentally retarded children, all the way down the scale of intelligence. The Commissioner stated that obviously, if this were to be attempted by the department, additional funds would be needed and greater appropriations would have to be made by the legislature for the purpose.

(Excerpt from the Minutes of the State Board of Education October 18, 1950)

WHAT CAN THE PSYCHOLOGIST CONTRIBUTE TO
UNDERSTANDING THE MENTAL DEFECTIVE?

Harriet Blodgett

I. Current views regarding mental defectives in society:

Recent years have seen a change in emphasis in work with defectives. We have progressed far beyond the ideas we had thirty years ago, when the aim was to have more and bigger institutions for defectives in order to protect society from them. We have moved from the position of stressing inadequacies of the mentally defective and his need for segregation to an appreciation of roles he can fill and ways he can be helped to fill them successfully. We have learned, in short, to take a more relative view and a more realistic one. We can accept the failures we have, study them to see what factors caused the failures, and apply our newly gained knowledge to the next group we work with.

1. In work with the individual defective, information comes from many sources: parents, school, social workers, doctors, nurses - to mention only a few. These sources furnish a good deal of insight and background which needs to be used; one handicap in its use, however, is that most of this information is based on observation under differing circumstances, and may not be comparable from case to case or from source to source. We need, in short, standardized observation.

2. Various testing procedures of the psychologist can contribute much new information, and can help integrate much "old" information.

II. The intelligence test, the psychologist's oldest technique: How it helps us to gain understanding:

1. Unevenness of ability in all individuals. In normals, because they have what we might think of as a higher base line, perhaps it matters less to study the unevenness. With defectives, since we expect less good judgment, less good use of experience, less ability to make wise choices for himself, knowing their ability patterns may be a vital factor in good or poor adjustment. We would consider some of these things:

- a. Differences shown between performance skills (involving concrete objects, manipulation, etc.) and verbal skills: what is the range in each area? are differences marked or slight?
- b. Does he have special abilities which could be used? (artistic, musical, mechanical)
- c. Does he have special lacks or handicaps which need to be avoided in vocational planning?
- d. What use does he make of experience?
- e. What is his approach to a novel situation?
- f. What is his level of language facility?

2. We may make use of special tests to measure some of these vocational aptitudes.

III. Observation of behavior and personality in the testing situation: with increased knowledge, there is a better realization that personality and intelligence overlap. We learn some things about intelligence from personality tests, and vice versa. Some factors we observe:

Marjorie Teslow

The social worker in the mental health program is in reality every social worker in the state. It must necessarily be so since each of us in some way has either a direct or an indirect contact with almost every person who enters or leaves a state hospital or school or with persons whom we assist in their efforts to make a satisfactory personal or social adjustment without recourse to hospital care.

Our responsibilities vary and our professional contributions are determined by the functions of the agency within which we operate. We may jointly serve a patient or we may delegate one to the other a role commonly assumed in relation to his needs.

The social worker in public and private non-institutional agencies must, I believe, re-orient her thinking about the mentally ill or deficient person. In her pre-occupation with duties generally outside the field of mental health the social worker has had little time or opportunity to increase her knowledge about the subject or to broaden her perspective so as to see the patient in his earlier family and community relationships, his current status, his admission to and discharge from a state hospital and his eventual return to home and society. It is understandable that many social workers have a lay rather than a professional point of view toward the psychotic person entertaining that common fear of him and looking upon his hospitalization as an end rather than as a means to an end.

This is equally true in relation to the mentally deficient. Institutional care in greater numbers of cases should be no more than a therapeutic interval during which the attention of the psychiatrist, the psychologist and the social worker is cooperatively directed toward helping the patient regain his equilibrium. The social worker's function intramurally and extramurally is to mend those breaches in interpersonal and social relationships which have contributed to the need for institutionalization and to mobilize the community's resources in his behalf.

A new area of responsibility is opening for the social worker in planning for these hospitalized persons. She must first maintain a continuing contact with the newly admitted patient so that there will be no drift to backward oblivion and secondly she must assume the initiative in bringing the forgotten patient on the backward to the attention of the doctor as a first step in restoring him to society. The social worker outside the hospital has the same responsibility. She cannot close her case during hospitalization since she must include the future in the present and begin proper preparations for the patient's return to society.

This of course is not to say that all patients can be helped to achieve normal mental health but we must condition our thinking positively, rather than negatively toward the end that our objective will be restoration not institutionalization.

In our concern for the backward patients we hope to move many back into society. For some it will be little more than the substitution of one setting for another with no marked change in behavior. Nevertheless, we feel that placing a patient in surroundings as nearly normal as possible is medically proper after institutionalization has served its maximum purpose. Such a patient, within his own capacity will derive from that change a varying degree of satisfaction. These patients will most generally be the harmless, chronically ill. It has been found in states where foster home care is an integral part of treatment plans that they often make a better adjustment than is possible in a hospital. Besides contributing something to the foster home in the way of small services, they occasionally find odd jobs which give satisfaction in inverse ratio to the monetary return.

A second group we may want to move out of the hospital is that in which such a step is a part of therapy; the group whose hold on reality must be tested and strengthened before return to their customary role in society is granted. For these patients, the foster home is an intermediary step, vital to recovery.

The social worker, both in and out of the institution, must combine forces to implement this philosophy. Interpretation to the Welfare Boards of the purpose of foster home care and the patient's right to support in such a setting, when he or his family cannot meet the costs, will be the responsibility of both. The task of finding homes and preparing the community for accepting such patients is shared. Supervision after placement should rest largely with the hospital staff so far as the mentally ill are concerned.

The hospital social worker has many functions. Some of these are being fulfilled in our institutions and others are dependent upon greater staff. The social worker ideally meets the patient on admission to orient him to his new surroundings, to allay some of his anxieties about being in a hospital, to ascertain what reality problems are disturbing him, and to lay the ground work for his eventual return home. In relation to the family she helps them to deal with their feelings about the patient's illness and assists in strengthening their ties to him. She broadens the base for the patient's restoration to home and society. Here again we must emphasize the need to consider hospital care as a treatment procedure and not a terminal point in a distressing personal or family embroilment.

During the patient's stay in the hospital, the social worker's contact with him may be either maximal or minimal, direct or indirect, dependent upon the jointly determined therapeutic plan of the clinical team. If in the discretion of the psychiatrist, the psychologist and the social worker, she is felt to be the person most likely to establish a purposeful relationship with the patient, then the contact will be close but constantly scrutinized by the psychiatrist. When the other members of the clinic team carry this responsibility, the social worker will turn her skills to those elements in the environment which must be modified to ensure continued building of the patient's own strengths so that his life will again be as full and satisfying as possible.

A concomitant duty is the training of other professional and non-professional staff. In respect to the former it is more of an orientation process, developing in the psychiatrist and psychologist an awareness of the impact of socio-economic and interpersonal factors upon the patient. With the non-professional personnel, including recreational workers, psychiatric aides and others, there is a growing recognition of the contribution the social worker can make in preparing them for their work with patients. She helps in the teaching of basic information about mental illness, in making the staff conscious of the personal worth and dignity of the patient, in maintaining a feeling each individual is an integral part of a larger group, and in interpreting some of the motivating forces causative of the patient's need for hospital care.

The social worker plays another role - that of a public educator. She is by virtue of her professional training, the liaison between the patient, his family, the hospital and the community. To prepare the way for the patient's eventual release the social worker must foster a readiness in the home and society for his return. Often this means extended interpretation of the purpose of his hospitalization and with its resultant improvement in his mental health his right to resume his former place in the community. Bringing the hospital to the community by means of talks, radio programs, movies, and informal teaching serves as one means of public education for the patient's benefit. The other channel is that of bringing the public to the hospital through volunteers who by groups or individually give of their time and energy to make the hospital stay pleasanter and more truly only an interlude in the patient's life.

1. Interest level
 2. General type of response - sluggish, slow, or flighty
 3. Attractiveness of personality to others
 4. Cooperation and motivation in the test
 5. Persistence
 6. Emotional control, frustration tolerance, response to failure
 7. Attention and concentration
 8. Something about self-attitudes: how does he treat himself and feel about himself
 9. Social skills
- and in the casual interview situation:
10. Interests and leisure time activities
 11. Values - what things does he hold as values to live by
 12. Ambitions
 13. Special aversions (to housework, for example)

7. Personality study methods: Problems in their use.

We have used paper and pencil techniques very little with defectives largely because of reading and comprehension difficulties. They are just not suitable measuring instruments for this group. Projective techniques opened up a new field: they provide unstructured materials on which the person can project his own mental content - his fears, worries, anxieties, loves, hates, etc. One handicap already had been provided in that a general impression had grown up that defectives were sufficiently homogeneous in personality and limited in potentiality so that the effort of studying personality structure in this group would not be worth while. Gradually this attitude is being modified. Two aspects to the use of personality study techniques: their diagnostic-study usefulness and their usefulness in therapeutic work.

1. Diagnostic study:

a. Use of the Rorschach: (ink-blot test - subject describes what the blot looks like to him). Used for gaining some information about intelligence as well as about personality. Most studies of defectives indicate these traits: limited mental content, little reflection, quick, concrete responses and impressions; lack of capacity for sustained conceptual thought. In relationships with people, tendency is to be superficial and limited.

(1) One difficulty: used with too few defectives to have established really reliable standards for its meaning with this group. Need more studies with more cases on which adequate medical and psychological data of other types are available - especially regarding causation and backgrounds of experience.

(2) Another difficulty: Rorschach is a complex and very time-consuming instrument.

b. Thematic Apperception Test: (series of pictures presenting situations involving crisis or appearance of crisis, rather vaguely presented. Individual tells a story about the picture, including in his story much information reflecting himself.) General findings from this test: Limited material produced - short stories, showing limited imagination. Often necessary for examiner to demonstrate what is wanted by telling a "sample story" first. Repeated themes appear in their stories: feelings of aggression, a desire for affection, rebellion against parents, feelings of guilt, insecurity, rejection, and ambivalence (alternating positive and negative feelings). These emotions point toward genuine rejection and deprivation, poor parent-child relationships, and evidence of conflicts and fears. Often useful in actual work with a defective to get a picture of possible sources of difficulty in adjustment. (Example: one girl who seemed to want to go to her own home very much showed clearly in her stories about pictures that her home did not really meet her needs. Results used to plan a better placement for her.)

c. Drawings, paintings also useful in bringing to light some of the feelings of the defective.

2. Therapeutic usefulness: generally assumed in the past that therapy would not be effective with defectives because intelligence was thought to be a necessary condition for therapy of any sort. Again, however, our concepts of mental deficiency have changed somewhat to stress emotional factors in functioning, whatever the capacity level; also, therapy techniques have changed. Both group and individual therapy have been found useful in treatment - mostly in institutional settings, and on a limited scale because of time requirements.

a. Non-directive therapy has been useful for problems of quarreling, temper tantrums, insubordination, stealing. Results have been evaluated by conduct and work records, discipline breaches. Improvements have been shown to result. Greatest obstacle to its use has been convincing institution authorities that it was worth a try, and that children could be handled without recourse to corporal punishment. Any therapy technique with defectives involves reassurance and often a direct type of approach.

V. Basic essentials of a program:

1. Must put the individual in a situation in which it is reasonable to expect him to adjust. (Example: a public school regular class with continual failure over a period of years plus rejection and lack of understanding at home cannot be completely compensated for by therapy. Compare this situation with that of a starving child who also has emotional problems: he needs to have the basic hunger taken care of before therapy for emotional problems can be effective.)

2. Assuming that the above basic essential is met, goals must be reasonable, too. Therapy will not make the individual who is truly defective into a normal person, but it can make him a happier, better adjusted, better functioning defective.

a. Problem of timing: probably more effective if carried on while the individual is still young and more plastic.

VI. Gains resulting from the use of psychological techniques:

1. For total adjustment: assist with training plans, prevent failure, prevent the development of frustrations and severe conflicts.

2. For the individual:

- a. Better understanding of how he feels and why he acts as he does.
- b. Better understanding of other people's feelings.
- c. Decrease in aggressiveness and self-defensiveness.
- d. Feelings of security, greater confidence, more self-acceptance.
- e. More appreciation of cause and effect relationships in behavior.
- f. More control of his own behavior, less anxiety and tension.

Public education is laborious demanding knowledge of existing attitudes so that the teaching techniques may be realistically directed to specific areas of misconception, ignorance and prejudice. Skill here is not solely the social worker's but she, in collaboration with others, must devote a part of her time to this phase of her professional duties.

There are two more spheres within which the social worker has a contribution to make. The first is in research. It is one of the weaknesses of social work and in great measure we have been an adjunctive service to other disciplines in their investigations. This does not deny the value of such cooperative efforts but we have problems peculiarly our own which need careful study. Independent research in social work in a mental health program has at least two areas in which to begin:

1. Investigation of socio-economic components in mental and emotional illness.
2. Testing and evaluating the concepts which guide our work in the broad field of social work as to its applicability to treatment of the mentally ill.

The final place of the social worker in a mental health program is in the out-patient clinic. Here she must be able to help those who are taking their first steps in readjusting to community living as well as helping those who are faltering in their efforts to control affective responses, to maintain an integrated personality, to live comfortably within their social relationships and who need support so as not to have to resort to hospitalization. The clinic worker, the hospital worker, and the social worker in private and public agencies meet here to pool their skills for the patient's welfare.

Obviously then, the social worker in the mental health program is every social worker in the state.

PANEL DISCUSSION

NOTE: The brief case histories given here had been sent to participants previously and copies were in hands of all attending the institute. In all cases everyone on the panel participated in much general discussion but only the main points brought out are recorded. As a whole the social workers asked questions to bring out different points of view, indicated the need of more detailed case histories and called attention to the fact that urgency for plans sometimes necessitated quick action. Due to sudden illness, Miss Henderson could not be present, and Dr. Delp substituted.

Irene Smith. Commitment considered in July, 1950.

CASE HISTORY.

Problem. Irene is not making a good adjustment. Intelligence quotients in border-line range. Should she be committed as mentally deficient?

Family History. Father is said to have had 3 years of high school education and mother to have failed 9th grade at age 17. Test in 1940 gave her an I.Q. of 78.

Irene has 4 half siblings whose ages range from 17 to 26. The youngest of these, Joe, is under commitment as mentally deficient with I.Q.'s from 69 to 79, and is in the Owatonna State School. There are 7 siblings. Of these Ben born 9-10-39, I.Q.'s ranging from 50 - 56 is committed as mentally deficient and is in Owatonna. Phil, born 2-17-43, I.Q.'s of 39 and 24, committed as mentally deficient in Minnesota School and Colony. Others tested, Dan, born 8-24-38, I.Q. 72 and Sonny, born 12-15-40, I.Q. 60. In 1938 Joe was removed from the custody of his parents because of abuse and neglect and mother's promiscuity. In July, 1940, Ben was removed for the same reason.

History of Child.

Social History. Irene, born 8-24-38, was removed from custody of parents and committed to the Director of Social Welfare as in need of specialized care in July, 1940. She was said to be disobedient with frequent temper outbursts.

She showed abnormal sex interest. Has had three boarding parents who have described her as uncontrollable, defiant, stubborn, "sassy", and unable to participate in play with other children. Her boarding parents in 1950 have tried to act as real substitute parents, but behavior the same. The boarding parents wished her removed.

School History. Is entering 6th grade on condition. School marks failing. Repeated second grade. Considered immature.

Psychiatric. Psychiatrist stated in 1948 she was an insecure and frustrated child. When seen at clinic a Wechsler Bellevue Scale form 1 was administered. Results verbal scale I.Q. 89, Performance 85 and full scale 84.

Psychological.

4-2-40	Bur.	Psyc.	Serv.	C.A.	1-8	M.A.	0-11	I.Q.	55	Kuhlmann
5-4-41	"	"	"		2-8-16	M.A.	2-2	I.Q.	81	Kuhlmann
4-1-42	"	"	"		3-7	M.A.	2-11	I.Q.	82	Kuhlmann
1-14-43	"	"	"		4-4-20	M.A.	3-4-21	I.Q.	81	Kuhlmann
4-22-48	"	"	"		9-8	M.A.	7-0	I.Q.	72	Stan. Bin. (L)

Examiner reported her nervous, nail-biter. Recommended further study to determine cause of maladjustment.

POINTS BROUGHT OUT:

MR. PEARSON:

There is often discrepancy in results of tests given prior to 2 years of age and later tests. Tests given under 2 years are of little value for predicting later results. Standard Binet is the basic test most generally used with children. Verbal I.Q. of 89 on Wechsler Bellevue a general finding with I.Q. 72-75 on Stanford. Wechsler Bellevue results usually give a somewhat higher score than does the Standard Binet for individuals in the borderline range. With I.Q. 72, social history very important in diagnosis. I.Q. alone not a basis for diagnosis as mentally deficient.

DR. DELP:

A mentally deficient child will not score 89 on the Wechsler-Bellevue Verbal Scale. This is a case of sociological and psychological problems. If special classes available as suggested by Mrs. Relf, Irene would not adjust any better.

DR. THORSON:

Practical question of plans involved. Admitting Irene is a seriously emotionally disturbed child doesn't solve this question. A major factor is her inability to meet school demands. On a practical basis psychiatric care not always available and emotional difficulties are not always correctable. Irene will need placement in a very special sort of environment; receptive and yet pretty firm for a considerable period of time. Irene is obviously in need of definite and long time help.

JUDGE UNDERHILL:

Commitment not a means to an end but an essential adjudication. The consequences are so tremendous to the individual that most courts feel commitment is only invoked when it has to be. At least at this time Irene not commitable as mentally deficient even though she might need help otherwise. More a dependent and neglected child. To add to this disturbed child an adjudication of mental deficiency is to compound what has already happened to her. In his court he would refuse to commit such a girl until she had demonstrated over a long period of time that her social adjustment was poor. He has a strong distrust of mental testing of young children; their progress so frequently blocked by poor environment. Also by the effect of being institutionalized even for a few years. Therefore every other remedy should be exhausted first. Child must show major social difficulties. Court must conclude that particular social conduct is the result of low I.Q. rather than environment.

MR. FRANK:

If presented to him he would file a petition on the assumption that all possible plans had be tried. Thinks Irene definitely comes under classification of mental deficiency. He considers the I.Q. and then with worker goes into social background. Thinks this is a young lady with (1) poor social background (2) three boarding homes in which she consistently showed an inability to get along. Does need guidance of state. Agrees with judge to this extent that a lawyer is always afraid of depriving an individual of his rights; however, in Irene's case thru commitment we are trying to secure protection for individual. She is mentally deficient from the legal standpoint. Definition of the law: so mentally deficient as to require supervision for their own or the public welfare. She needs supervision.

NOTE:

Lack of sufficient information was noted by several discussants, and as no one from Irene's county was present details were not possible.

MODERATOR.

In general the agreement of the majority would be that with evidence presented at this point commitment is not justified; but if with the facts here it can be shown that every effort has been made to play otherwise and the behavior continues, then the filing of a petition might be justified.

Mary Price. Commitment considered in September 1942.

CASE HISTORY.

Problem. Gave birth to third illegitimate child. Some plan must be made. Intelligence quotients above 70. Should she be committed as mentally deficient?

Family History. Mary sixth in family of 11 children. The home was an average farm home which had been given good care. Welfare board members in community reported Mary's father frugal and stubborn, a man who takes the earnings of his children. Her mother seemed rejecting and her brothers and sisters were ashamed of her.

Girl's History. Born 6-1-19

Social History. Children born 6-26-37; 3-15-41; 6-8-42. Paternity was not established for any of them. The first 2 were in the home of her parents, resented by her father and tolerated by her mother. No aid had been extended in helping Mary make an adjustment after birth of first 2 children. The third child would not be kept at home. The third baby was born in a maternity hospital. She was reported there to be a willing worker, but in need of considerable supervision. Lacked initiative and self reliance and in even the simplest duties detailed directions must be repeated every day. Happy-go-lucky. Immature emotionally.

School History. Mary reached sixth grade in school in 1934 and was promoted to seventh. Repeated fifth. All of marks in sixth were B and even in year when she repeated she had B in reading and writing and A in spelling.

Psychological.

Date	Bur. etc.	C.A.	M.A.	I.Q.	Test used
7-16-42	Bur. Psyc. Serv.	23	10-11	73	Stanford Binet I

Wechsler Bellevue, verbal 81.

POINTS BROUGHT OUT.

MRS. JACOBSON:

Mary certainly needs someone to look after her. For that reason commitment would be for her advantage.

DR. THORSON:

Some definite plans must be made. Would favor commitment because of repetition of illegitimate pregnancies, inability to work except under direction, and a family unable to accept her need for continued direction.

DR. DELP:

There is need for definite achievement tests rather than school marks.

MR. PEARSON:

Promiscuity, had she not become pregnant repeatedly, might have resulted in a false appearance of normality.

MRS. REIF:

Is poor family background one basis for commitment?

MR. FRANK:

Background a factor and also need for protection.

JUDGE UNDERHILL:

This is the kind of young lady who has demonstrated that her ability to control her social conduct is much lower than her test results. Added all together she is mentally defective and so committable. Her ability to do further social damage requires protection for perhaps all of her life.

THE MODERATOR.

There is unanimity of opinion - general agreement on advisability of commitment.

Berry Family. Commitment considered in September, 1948.

CASE HISTORY.

Problem. Family had long been known in the community. When the father was arrested in September 1948 on a charge of carnal knowledge with his stepdaughter Martha White it became necessary to make plans for all of the family. Should some members be committed as mentally deficient, and if so, which?

Family.

Father Stanley Berry Senior	Born 3-25-09
Mother Mary Ann Berry	" 2- 2-09
Children Martha White (child of mother's first husband)	" 4-25-33
Chris White	" 11-15-34
Frances	" 1-24-37
Phyllis	" 3-13-40
Peggy	" 7-22-42
Stanley Jr.	" 2-14-44
Norma	" 4-14-45
Ben	" 4-25-47

General Family and Home Conditions. Living conditions "deplorable". Family lives in 3 rooms of a large old farm house. Furniture - 3 beds, 2 benches, a table and a stove. Home dirty. It was felt that all were low grade. Affection in family evident and they appear happy. Appearance of children attractive although clothing always ragged and dirty. Family does not attend church. The only relative in Minnesota was an uncle of Stanley's where home conditions were little better.

Individual Information. Stanley Senior a farm laborer by hour or day when he could secure work. Relief always necessary during winter months. Over a period of several years he had apparently shown a special interest in Martha White. He would take her to picture shows but not take the other children. Arrested in September 1948 on charge of carnal knowledge.

Mary Ann. Although the home was so badly kept she canned about 500 quarts of vegetables yearly from the garden. She seemed unable to understand the meaning of her husband's arrest, though 2 years previously had been warned he paid too much attention to child. She was said not to appear worried over arrest, but rather excited.

Martha White. In sixth grade. By March, 1948 "reached level of ability."

Chris White. In fourth grade. Out of school one year because of illness. Likes to work with tools.

Frances. Had started school at age 6½. Remained 2 years in first and then removed as teacher in rural school could not give individual help - discipline problem, disobedient, talked loudly and disturbed school; however, could dress herself including tying her shoes and go to toilet alone. Was taken to University Hospital in 1947 where it was reported test reports were verified by clinical impression. Said to be operating at imbecile level. Commitment as mentally deficient recommended.

Phyllis. In third grade.

Peggy. Appears alter; affectionate.

Stanley Jr.)
) do not talk intelligibly, but make wants known.
 Norma.)

Ben. Unable to hold up head. Bed until 9 months was an orange crate.

Psychological.

	Date		C.A.	M.A.	I.Q.	Test Used
Stanley Sr.	1-28-48	Bur. Psyc. Serv.	38-10	10-0	.67	Stan-Binet L
Mary Ann	1-27-48	Bur. Psyc. Serv.	38-10	8-6	.57	Stan-Binet L
Martha White	1-28-48	Bur. Psyc. Serv.	14- 9	8-8	.61	Stan-Binet L
Chris White	1-28-48	Bur. Psyc. Serv.	13- 2	7-10	.60	Stan-Binet L
Frances	1-28-48	Bur. Psyc. Serv.	11- 0-1	5-6	.50	Stan-Binet L
Phyllis	1-28-48	Bur. Psyc. Serv.	7-11	6-1	.77	Stan-Binet L
Peggy	1-27-48	Bur. Psyc. Serv.	5-6	4-10	.88	Stan-Binet L
Stanley Jr.	1-27-48	Bur. Psyc. Serv.	3-11-13	1-9	.44	Kuhlmann
Norma	1-27-48	Bur. Psyc. Serv.	2- 9-13	1-3	.46	Kuhlmann
Ben	1-27-48	Bur. Psyc. Serv.	0- 9- 2	0-7	.78	Kuhlmann

NOTE:

The first reaction of all the panel was that no family should be committed collectively." It was emphasized that members of the family were to be considered on an individual basis.

POINTS BROUGHT OUT.

JUDGE UNDERHILL:

It is unfortunate the mother had not been committed earlier. She should be committed first, and perhaps considered for sterilization, and then remain at

home. The father's problems are temporarily met by the prison term. Commitment might have been better since crime may be due to mental deficiency. Martha might be committed but the others need further study.

DR. THORSON:

Frances is the one who seems the greatest problem. He also wondered if the mother might be more competent than indicated by the I.Q. and could hold home together without father. (County worker stated she was extremely dependent on her husband's judgment.)

MR. PEARSON:

All might be considered mentally deficient, but commitment not recommended except for parents and possibly Frances after thorough study. Recommended dependent commitments for others. On question of commitment following only one test, he stated it never should be done for a three or four year old. When older, only when findings are coincident with physical and emotional findings or in a family like this. All of these children should be retested after a boarding home placement. Only one test sometimes accepted for adults because of lack of time.

DR. DELP:

A critical attitude must be kept towards considering that poor environment and low intelligence rating go together. More than one test should be given an a careful diagnosis made.

CLARIFICATION BY COUNTY.

At this point the need for immediate plans for the family was stressed and the county worker gave some of the complicating factors as follows: (1) Rather difficult in rural areas to find boarding home even for children who are "normal." (2) No special school facilities whatsoever for retarded or slow children in her county. Handled by social promotions. (3) They had tried to find boarding homes in other counties where there were better school facilities but not very successful in this. (4) Consideration of housekeeper impossible because the family were only given three weeks to vacate. Housing situation also bad in county. No possibility of suitable home - nobody would rent to a family of 8 children, and so there was no place to put them as a group.

In further discussion the practical question of plans was taken into consideration by most of panel.

POINTS BROUGHT OUT.

DR. DELP:

Possibility of a wrong commitment still calls for boarding home placement and observation.

DR. THORSON:

Plans available to workers too scanty and if there were not so few facilities there would be no argument. Doctors and others overlook the fact there just are no facilities available, including those for psychiatric study.

MISS THOMSON:

What will happen to the children while waiting two or three years without proper schooling and perhaps in several homes and without social acceptance?

JUDGE UNDERHILL:

In such circumstances if the social worker is satisfied that an individual should be committed he might be justified in bringing to the attention of the court. A wrong commitment might injure an individual and every American must have his constitutional rights protected. The impression a person makes on the three members of the examining board will be the determining factor in determining whether a commitment should be made. Ideally in this case there should be a period for further study, but practically a petition might be filed for all of the family with the lower intelligence quotients, and if doubtful of action the Court has authority to order further study.

NOTE.

A social worker in the audience emphasized the serious problem of the county finding boarding homes for so many children and of their cost as it would be probably at least \$360 a month.

MRS. RELF:

Commitment may not be a disservice. It would secure opportunities not otherwise available. In any case if an error was made, the state would petition for restoration.

THE MODERATOR.

The consensus of opinion is that each member of the family must be considered individually. In the case of the children ideally there should be more study for each - psychological and perhaps psychiatric. However, practically the children with lower I.Q.'s might be brought to the attention of the court, leaving it to the court to make the final determination.

Irene Green. Commitment considered in October 1950.

CASE HISTORY.

Problem. Some psychological tests give borderline results. Irene is under guardianship as demendent but will soon be 21. With close supervision she has adjusted well, but it is felt she will not adjust without supervision. Should she be committed as mentally deficient?

Family History. Parents Irish immigrants. Father died of brain tumor 1930. Mother with I.Q. 52 committed as mentally deficient in 1936. Died 1947.

Older sister and brother and younger brother. All have I.Q.'s indicating average intelligence.

Until father's death children lived in an army camp. Irene especially neglected by her mother.

Girl's History. Born 10-24-29

Social History. Before mother was committed as mentally deficient Irene was removed from home. Aunt kept in touch for a time but no other family contacts. Supervised by private agency in several boarding homes.

2-4-38 Committed as a dependent child to Director of Social Welfare.

1-25-38 Placed in boarding home where she was given special consideration and love. Still remains there. Boarding mother did not expect too much and found her forgetful. Poor worker because of this.

Irene neat on job, otherwise slovenly. Since earning money she has become difficult in boarding home. Shows little idea of value of money but boarding mother helps her budget. Displays violent temper and has actually injured a smaller girl in temper tantrum.

School History. Entered kindergarten in 1936. Inattentive and distracted other children. Attended a special school for mentally retarded. School has noted great improvement since being in boarding home.

Work History. In June 1947 vacation employment secured with Inweaving Company. They worked hard with her, but she was not successful in learning work.

In September 1948 secured job as waitress in employees dining room of a hospital. Has been taught certain routine tasks and carries out instructions for these. Failed civil service. Cannot carry out varied work or use initiative. Supervisor kind but keeps strict discipline.

Medical and Psychiatric. Incubator baby because of rickets. Several months after leaving hospital as infant she was returned because of her poor physical condition. "A fluid condition between the scalp and the skull" was noted. Relatives thought this was because the mother had knocked the child's head against the wall. Physician thought it might be result of poor health condition. She walked at two. Had rickets. Bed wetter. Much of 1932 spent at Gillette Hospital because of deformity of upper femur. 3-11-37 x-ray of head showed slight birth injury. While asleep her muscles "jumped". Often she would sit up in bed while asleep. Hands shook when she came in from play. Doctor did not think it chorea. Psychiatrist thought movements a part of severe emotional disturbance.

Psychological.

Date	Bur. etc.	C.A.	M.A.	I.Q.	Test Used
2-26-32	Bur. Psyc. Ser.	2-4	12-8	46?	Kuhlmann Binet
12-61-37	Bur. Psyc. Ser.	8-1	5-7	69	Kuhlmann
5-20-48	Bur. Psyc. Ser.	17	9-10	65	Stanford-Binet L
9-20-50	Bur. Psyc. Ser.	20	11-8	75	Stanford-Binet M

Also in 1935 and 1936 there were 3 tests by a child Guidance Clinic with I.Q.'s of 76, 84, and 81.

NOTE:

Early in the discussion the county social worker was asked more concerning boarding home. She stated that Irene was well protected and it was only when she started work that she showed the reported behavior.

POINTS BROUGHT OUT.

DR. THORSON:

This girl has something wrong with her. Whether it is emotional or physical we can't tell. A number of such cases known to him who had not been committed has gotten into trouble. On the other hand there are those who do get along and one can't go committing people just to get a hold on them. The erratic behavior is suggestive of brain injury and if that is the case she would not respond to treatment and plans should be made on a permanent basis. (MISS COAKLEY pointed out that this was a reason for asking for developmental histories with full medical and social information).

MR. PEARSON:

The earliest test should be disregarded. Emotional instability of Irene might account for some discrepancy in test score. Without reviewing original records he could not give reason. Would like to have further tests given.

DR. DELP:

Called attention to the fact that Irene had been in the same boarding home for years, had attended special classes and that in spite of everything being in her favor she still failed to make an adjustment.

MR. FRANK:

Had presented this case to his court. He had felt it necessary for Irene's protection. In court she seemed to have not appreciation of practical problems. The Board had advised the boarding mother to try to teach her, and that perhaps at a later date she could be restored.

NOTE:

The question was asked from the floor whether guardianship for protection was compatible with judicial responsibility.

JUDGE UNDERHILL:

In reply to question stated it could not be done unless the court could make a primary finding of mental deficiency. The legislature has set up certain standards that must be met before you can take over this responsibility. The court does two things: (1) adjudicates that as of today the person is mentally deficient (2) it takes control away from parents and from the patient and places it in an agency. Even if the agency intends to exercise authority for the benefit of the person, the court must not take away freedom unless essential requirements can be met. Social workers sometimes get into difficulty because they do not understand the difference between judicial and social work responsibility. From the social work standpoint the workers are trying to improve conduct, raise the individual standards and protect the person and the community. From the legal standpoint the consequences are so drastic that one hesitates to invoke commitment unless there is dire necessity.

MODERATOR:

There seems to be unanimity of opinion that commitment was justified.

Daisy Jones. Commitment considered in October, 1950.

CASE HISTORY.

Problem. Daisy is a child some of whose tests have been in a borderline range and some in the moron. The public school recommended commitment as she needs training that city schools cannot give. Her conduct has necessitated supervision by the probation office. Her mother is unwilling to have commitment made now. Wants to wait and see how she gets on. Should petition be filed in spite of mother's opposition?

Family History. Mr. and Mrs. Jones, age 45 and 41 were married in 1925 and have five living children with an age range of 6 to 20 years. Mr. Jones was a painter by trade and was not regularly employed between 1932-46. The family received relief continuously from 1930 to 1942 and reapplied in 1946 when Mr. Jones was unemployed.

He is reported as being a heavy drinker and this is believed to have resulted in his frequent loss of jobs. The Department of Public Relief case was closed on 3-7-46 when he obtained employment, and on that same date he was placed on probation for non-support of his family. Home is in a poor district of the city. Badly in need of repair. Housekeeping standards very poor.

History of Child. Born 12-17-36.

Social History. In 1949 Daisy was committed to Home School for Girls when brought into Juvenile Court on charge of intercourse and promiscuity and because of running away from home and school. Ran away from HSG twice within two or three weeks and then allowed to stay at home but put on probation. In summer of 1950 she and other girls had been "picked up" by an older man. Daisy said he got fresh but she did not have intercourse. Mother says girl is problem even since on probation as she will run away if not watched. Also resents her "dumbness". Is felt by social worker and probation officer to have an excessive interest in sex. When seen on 8-25-50 was playing with other children but was wearing a low-cut dress of silky material. Hair was uncombed. She showed no respect for her mother.

School History. Daisy attends special classes. Her school adjustment necessitates constant attention and supervision. She is frequently truant from school or will appear at the school but will not go to her room. She occasionally does fairly good work but usually is rude, resistant and impudent.

Psychological.

6-24-42	C.A.	M.A.	I.Q. 83	Kindergarten Bin. Int. Test
3- 5-45	C.A. 8-4	M.A. 6-2	I.Q. 74	Stanford-Binet form L
3- 5-45	Reading grade 1.6			Monroe Diagnostic Reading E
3- 5-45	No major areas of maladjustment except for a score in self-reliance at the fiftieth per.			California Personality Test

POINTS BROUGHT OUT.

MRS. RELF:

Thinks she would be willing to file in order to protect girl. Her experience was that there is less opposition than expected when the social worker relieves the family of responsibility.

DR. THORSON:

There was nothing for Daisy but commitment. The family has made it necessary for the social worker to impose himself on the situation. Daisy would probably meet the criteria of a social adjustment not commensurate with I.Q.

JUDGE UNDERHILL:

The welfare board is not only justified in filing, but has a positive duty. Where there is a public problem and initiative cannot be left to the family. Commitment is permanent but a flexible and adequate means of control.

MODERATOR:

(After statements of agreement from others) There is unanimous agreement the welfare board has an obligation to file a petition for a hearing in mental deficiency in a situation such as this.

William Rand. Commitment considered in October 1947.

CASE HISTORY.

Problem. William a serious community problem. Although only 17, considered with adults since almost beyond age when he would be considered a juvenile in delinquency proceedings. During study diagnosed as a psychopathic personality with asocial and amoral trends. He must be removed from the community. Should he be committed as mentally deficient?

Family History. Father has ninth grade education. Has brought up boys alone - some times in boarding homes. Hard worker, usually common labor. In 1947 working in forestry service. Slow and easy going. Has tried to do his best by his boys. In 1947, father and two sons living together. House kept clean. William's brother apparently doing more work than William.

Mother completed ninth grade at school. Said to have been an attractive, modern young woman. When married, wanted to have a good time, not settle down. Did not want children and gave them poor care. Divorced in 1937. Remarried and lives in nearby town. Considered "a common tramp." Uninterested in sons.

William's only brother, 14 months younger, was a fine boy and good student. Was in the tenth grade by 1947.

Boy's History. Born 8-6-30.

Social History. Brought to the attention of rural welfare board in March, 1947, by the Sheriff. Neighbors had reported he was stealing, breaking into homes, using rifle indiscriminately and was a danger and menace to the community. Removed to boarding home in another neighborhood. Brought to University Hospital for study in adult clinic on 5-26-47. Following return was placed in boarding home. He began stealing "inciting" children to smoke and was a general nuisance. Second boarding home - same experiences plus setting a fire. "Sits and dreams". Undependable. Promises to do better, but has no effect. Third boarding home asked removal in September.

School History. By the spring of 1947 William had been placed in eighth grade in the public school of a small rural town because superintendent felt sorry for his father.

He had not done the work. Had been a great deal of trouble and learned nothing. Would ride to school in bus and not show up. Steal and cause trouble by attitude. Failed all subjects in 1945 and 46, but returned in September, 1946, dropping out before end of school.

Psychiatric. Study at University Hospital Clinic 5-26-47 including a mental test on the Wechsler Bellevue scale. The result was an I.Q. of 81. It was not felt "that his problem was too serious from a psychiatric point of view nor that he would respond to psychotherapy." Diagnosis - Psychopathic personality with asocial and amoral trends. Prognosis poor. Boarding home placement recommended.

Psychological. On recommendation of a state psychologist William was placed in Children's Center 10-8-47 for psychological study.

Date	Bur. etc	C.A.	M.A.	I.Q.	Test used
10-10-47	Bur. Psyc. Ser.	17	9-10	66	Stanford-Binet L

POINTS BROUGHT OUT:

DR. THORSON:

Pointed out the home situation which led to this problem - very serious rejection by mother, and father not able to make up for it. Younger brother better. Not unusual for first child to be the most rejected by a mother like this. History indicates that something must be done. Diagnosis of psychopathic personality easy to make but one doesn't always know what it means. Such children are not ones who are easily treated. Feels probably he should be committed. Would give much better means of handling him and could hold on to him for a longer period of time. Wondered if he might be schizophrenic. If a boy like this is put under sufficient stress he may become psychotic. Committing him as mentally deficient might prevent later psychosis.

MR. PEARSON:

There is a marked discrepancy between Stanford Binet and Wechsler Bellevue. In this kind of individual one might expect this discrepancy because Wechsler emphasized performance more. In favor of commitment. Judges do not understand difference between Wechsler Bellevue and Stanford Binet. Wechsler Bellevue is more a psychologist's tool and Stanford Binet is used more to show the actual level and terms of numerical results. Wechsler Bellevue gives a much more restricted range generally agrees much more closely with Stanford Binet results in these cases. Where psychopaths are concerned he feels it a duty to protect the public from future difficulties that are almost certain to occur as well as to protect the individual from results of his own actions. Furthermore, these individuals typically do not mind commitment. Laws should be revised to provide for commitment of psychopathic personality.

JUDGE UNDERHILL:

Commitment warranted. As in all cases the primary point to remember is that the social incompetence must be the result of mental deficiency.

MODERATOR:

Again there is unanimous agreement that commitment is justified.

THE PLACE OF THE INSTITUTION IN A PROGRAM OF CARE AND TRAINING OF
THE MENTALLY DEFICIENT

E. J. Engberg

As you know, our Institution is now known as the Minnesota School and Colony, in accordance with the change made by the 1949 legislature. This Institution has functioned since 1879 as a home and training school for all ages and all degrees of mental retardation. In 1925 the first change occurred, when epileptic patients were transferred to Cambridge for patients with convulsive disorders, which is now known as the Cambridge State School and Hospital. We still have at Faribault the non-ambulatory epileptic who is of low mentality and helpless, and we also have accepted transfers from Cambridge who have required isolation because of tuberculosis.

The second change occurred in 1945 when the Owatonna State School was made available to the Director of the Division of Public Institutions for the admission of the children committed as mentally deficient who were sufficiently educable to become self-supporting after receiving training. As a result, in July, 1945 we transferred 233 boys and girls under 19 years of age, and since then have not admitted such children unless they could not participate in the Owatonna program because of a severe physical or emotional handicap.

Due to the large relative increase in our population of helpless patients and patients of very low intelligence, many of whom present serious behavior problems and who are most urgent on the waiting list, a definite increase in the number of nurses and psychiatric aides has been a necessity. The 1949 legislature met this need in large part by greatly increased appropriations for additional employees. Our authorized positions were increased from 410 June 30, 1949 to 590, of whom 323 are nurses or psychiatric aides. These additional positions are staggered over a period from July 1, 1949 through January 1, 1951.

You are familiar with the Mental Health Program which the 1949 legislature adopted under the leadership of Governor Youngdahl, and which has, in addition, resulted in a marked improvement in the quality of food and clothing for our patients, as well as more new furniture and furnishings. For example, the aluminum dishes are being replaced by plastic ones in attractive colors. Aervoids, which are huge thermos containers, are being acquired for keeping foods and liquids hot or cold until served. A truck for conveying food to the more distant buildings, has replaced the slow, horse drawn wagon.

Provisions for additions to our medical staff have been made, so that where formerly there were six positions there are now nine, of which five have been filled. A pediatrician, Dr. Heinz Bruhl, has recently been added.

This Institution is included in Dr. Rossen's program for the mental hospitals, and we are benefited by the services of consultants. Dr. Elmer M. Hill is available for consultation regarding skin conditions, while Dr. Lyman Critchfield serves in pediatrics. Dr. George D. Eitel has continued to serve as surgical consultant, which position he has filled for many years, as well as Dr. F. W. Stevenson, the consultant in eye, ear, nose and throat.

The Social Service Department has been increased from one to four positions, three of which are filled. One Social Worker, Mr. Edwin Lehtinen, is in charge of the assignment of patient helpers to work training within the Institution. It is helpful to have someone who is in a position to study the type of training best suited to the ward, for whom placement in the community may be possible at a later date, and also to assist others to become happily adjusted during their stay.

A full time psychologist, Miss Violet Greenberg, and an intern in psychology, Miss Ella Aidel, are now on the staff. A chaplain, Reverend Berthold Steufert, came the first part of September. There are nine recreational workers under the recreational leader, Mr. Milton Hustad, who are in a position to carry on a program of recreation, going even to the wards where the patients are too physically handicapped to come to the assembly hall for activities, or are too slow mentally to participate in the movies, dances, and other entertainment.

The School Department has a three-fold purpose: 1. To provide nursery school and kindergarten training for the small children, many of whom will never advance any further, and to determine by teaching and by the advice of psychologists, whether or not any of these children can advance enough to be transferred to the Owatonna State School. 2. To provide special tutoring in an ungraded room for the older children who have double handicaps, such as a crippled condition, emotional and behavior difficulties which preclude their adjustability at Owatonna. Occasionally one of these cases, after a period of training here, may be recommended for transfer. 3. The School Department has a number of sewing, handicraft, and industrial rooms in the school proper as well as in the various divisions, which are maintained for the training and occupational therapy of the young adult. A new principal, Mr. Howard Hall, has recently been added to head the staff of 12 teachers. He, with the help of the psychologist, is interested in screening our population so that any child who can benefit by school training has an opportunity to be included in a class, even if it is only a part time one.

Our heads of departments participate in the meetings at Anoka which are in reality in-service training programs prepared for the Hospitals for the Mentally Ill, Cambridge and Faribault personnel. Twice, training teams have visited our Institution and worked with the aides in particular wards where the patients needed a reactivation of their daily program. Our staff has a nursing instructor who is in charge of an 80-hour in-service training course given at the Institution for all aides. Other Institution employees must attend a portion of this training class.

The building program at present consists of the completion of two new residences for physicians, enlargement and remodeling of the kitchen facilities, and the addition of three new dormitories, ground for which was broken in September. These last may accommodate about 300 from the waiting list, although our present population of 2894 means that we are seriously over-crowded and should move 100 or more of our patients into these new buildings. They will be the geriatrics type in order to provide care for our older and crippled patients who are unable to go up and down the stairs.

As you probably know about the routine which is followed here when a patient is admitted, we need only state briefly that the pre-entrance physical examination is very helpful to us, and that we appreciate the fine cooperation of the Bureau for Mentally Deficient and Epileptic, the County welfare boards, the local physicians and the families of the wards in preparing persons for entrance. The danger of contagion is minimized by this screening, and our staff physicians and laboratory technician are assisted immeasurably by the reports which are sent to us in advance. We also appreciate the copies of case histories which are made available to our staff by the Social Service department at the case conference, at which all new admissions are presented.

One attribute of the development of the Mental Health program might be emphasized: The lessening of a feeling of stigma or shame attached to the concept of mental deficiency. We believe that the relatives and friends of patients, as well as the community, are coming to the viewpoint that mental deficiency is an accident of birth, with reference to which there should be no approbrium. You, yourselves must also have noticed this improved acceptance of the unfortunate one on behalf of others.

In conclusion let us emphasize that the Institution no longer serves as a place where the loved ones are bought with the concept that they are being "put away", but rather after admission they are still studied and treated as individuals and are given a program of care or training in accordance with their mental ability and their physical needs, in order that they may be as comfortable and as happily adjusted as possible.

CAMBRIDGE STATE SCHOOL AND HOSPITAL

R. J. Gully

It appears from all available information, that about one-half of one percent of the population is suffering from some convulsive disorder, while about five percent are suffering from a mental deficiency. If this ratio remained constant, about one in every two-hundred of the mentally deficient individuals would also suffer from convulsive disorders.

I believe that the fact exists, and is accepted by most, that the ratio of the convulsive disorders of the mentally defective group is much higher, which has also been stated in the discussion accompanying the picture shown. This bears out the point that there is a possible relationship in the mentally defective individual and the one suffering from a convulsive disorder.

I believe that the previous picture would lead one to believe that all convulsive disorders are mental deficient or undergo a process of mental deterioration. This is a little misleading in that some individuals with a convulsive disorder have, and retain, a relatively high I. Q. In fact, some are considered mental geniuses and undergo little or no mental deterioration; while others undergo a considerable degree of deterioration.

The number of seizures the individual has is no definite criterion as to the extent of the deterioration that takes place, as some individuals with few seizures undergo considerable deterioration, while others undergo little or no deterioration. Nevertheless, we are inclined to agree that the convulsive disorder may produce a certain number of mental defectives. Yet, we must not lose sight of the fact that mental defectives and the convulsive disorder, in many cases may have a common cause, such as head injuries of various types and ages, as well as various infections, also a tumor may have the same etiological factor. In other words, the mental deficiency may not be due to the convulsive disorder, but the convulsive disorder due to the same factor that may have caused the mental deficiency.

I believe we noted that a pair of twins were suffering from a convulsive disorder. This immediately leads us to question the possibility of heredity as the factor for the convulsive disorder. This, I am afraid, may be a faulty conclusion. It is true, that this would seem highly possible, yet we must realize that these two infants were confined to the same contracting uterus, passed through the same pelvis, which may have been rather small, resulting in similar head injuries in each case. They were also infants at the same time, and in all probability were exposed to the same sources of infection.

We do not wish you to believe that we deny the fact that heredity may be a factor in the convulsive disorders, as it appears that the ratio of convulsive disorders is more frequent in cases where the parents are suffering from this particular disorder. In fact, the ratio is about from one to sixty, while in the average population, it is about one to two hundred.

To divert to another phase of the picture, we note that different types of seizures are shown, and it is interesting to note that the same causing factor may produce different types of seizures in the same individual. In other words, the convulsive disorder, due to post infection, brain injury, or brain tumor may result in grand mal seizures in some, and petit mal seizures in others, or may result in both types in the same individual.

As noted, the petit mal type of seizure is a very minor affair and may pass unnoticed in many individuals for long periods of time, or not at all by individuals with whom they come in contact. This condition, when it exists, is often taken too lightly, as these people may be the ones to suffer severe injury or be the cause of inflicting severe injury to others. From this period of momentary loss of

consciousness, many complications may develop such as falls from high altitudes, road accidents or other misfortunes.

As noted, the grand mal seizures are a very spectacular condition and often-times frightening to the people who are unaccustomed to seeing them. The average length in time is about three minutes, but as one looks on, it seems that the individual is never going to relax or recover.

The Jacksonian type is not so alarming to see, since the individual retains consciousness and may be able to converse during the period of the convulsive seizure.

As this picture was made some years ago, we are undoubtedly wondering about the developments and knowledge gained of the convulsive disorders since that time. In realization of this, we must be aware of the fact that the convulsive disorder is one of the oldest known disorders and one which considerable knowledge is still to be learned. There is still a question in the minds of all as to how this condition can be alleviated. During the past years, many contributing factors have been added to an explanation for the cause of the condition. Some advancement has also been made in controlling seizures by the various anti-convulsive drugs, but little has been accomplished in curing the condition, and it is believed by many, that we should not feel that the individual cannot ever be cured. A rather recent development which is known as the electro encephalogram has come into use. This is a rather complicated instrument which will record the amplified brain waves. This is now used as a diagnostic feature and an index for the use of certain anti-convulsive drugs used in the treatment, but in itself, has no therapeutic effect. It is rather unfortunate that many lay people labor under the opinion that it may have some magic power to facilitate a cure for the condition.

THE PLACE OF THE LOW GRADE CHILD IN A PROGRAM
FOR THE MENTALLY DEFICIENT

Barbara Kohisaat

As I prepared for this discussion this morning, so many things came to my mind that I suddenly realized I was in danger of wanting to talk about enough things to keep us going for at least a day. In the inevitable narrowing-down process, I have decided upon 2 aspects of the many problems relative to the low-grade mentally deficient that pertain particularly to the casework we do:

1. Managing and understanding ourselves as the people involved in planning for these children.
2. Working with the parents to help them make sound, comfortable plans.

One of the things this narrowing-down has had to eliminate was a chance to think about our responsibility and contribution at a community level. It isn't enough to confine ourselves to doing the best we can within the program and facilities that exist today -- indeed, it would be enough to send us running the other way if we thought things would never be better, if we had to go on forever holding our fingers in the dyke as we certainly are doing now considering the enormous waiting list and the appalling general public ignorance about this problem. I can only hope that some of what I shall present will, in its own way, have bearing on this very important part of the total problem facing us.

MANAGING AND UNDERSTANDING OURSELVES AS THE PEOPLE INVOLVED IN PLANNING FOR THESE CHILDREN.

In thinking about the case worker who carries the responsibility of helping to carry out plans for the low-grade mentally defective child, there are two principal things to think of: 1) What it means to the worker to be a person in this helping role, and 2) What mental deficiency means to him personally. Until we have been in this kind of work for a while, we are likely to think we have no attitudes which can in any way affect how we do our jobs, but one day along comes something that makes us feel too mad or too blue to think clearly. Then we are startled, and we wonder what has gone wrong. As new, and perhaps even no such new workers, we need to recognize the no matter how "chancey" are the circumstances that lead us into these jobs, we are here because we get satisfaction out of helping people. If we weren't that kind of people, we would be doing something different. The first and hardest thing to learn is that real help is not carrying out what strikes you from your less involved viewpoint as the answer but in making it possible for the person whose problem it really is to come to the best solution for him and be able to stick with it once he's gotten there. It also means becoming comfortable with the fact that there are limits to what can be done, over which we have no control, accepting that this is so, and going on from there. I doubt if any social worker can be more solely tried in this respect than the one who is helping to plan for the low-grade child. At best, we can only help the parent make the best of a tragic situation but to do this well is far far better than it seems at first glance.

It is good to be a person who likes to help -- it is nothing to hide from ourselves or others. It is equally important, however, to know and think about it so that we can be clear-thinking and sensitive to the feelings of the person who needs our help, so that we don't put our goals ahead of his goals and end up by satisfying neither.

A further complication can arise when we start working with the handicapped for the first time. For the most part, few of us have any personal familiarity with this problem or have known any mentally defective people before we get into this work. Thus, being human, we share all the misconceptions and fears that are normal to all people faced with something that is strange and therefore mysterious. It is normal at first to be uncomfortable about human beings who are different -- the classic attitude about people in state hospitals is a good illustration of this. What we often fail to do, however, is realize that it isn't something peculiar to us alone and so are critical of ourselves and put it aside as unworthy. Putting aside is less effective than it seems, however, so that somehow we are affected nevertheless. We may turn to other more acceptable things but what happens more often is that we become over-identified with the problem and lose our clarity in seeing what is really the best way out.

I know from my own experience how all of this feels. My very first job was in an institution in another state and I can remember as vividly as though it were yesterday sitting in the lobby of the school waiting to see the superintendent about the job. Many of the patients came by as I waited, some of them pushing the wax mops so familiar to institutions. I was really rather scared of them -- they seemed like creatures from another world and just as unpredictable and threatening as such unknown things always are. The uneasiness continued for a little while after I started working even though I was happy to have this particular job. It was well illustrated by the way I jumped my first morning there when I was awakened by a hard slap on the back and a voice saying, "Get up, 'shreepyhead'!" Needless to say, in a very short time, as the patients became individuals to me, I was no longer troubled by these feelings and instead developed strong affection and concern for them.

Now why do I make such a point of all this -- what difference does it make? Even while we want the caseworker to be a sympathetic person from whom parents can get real support and help, we know that if he is suffering even some of the same anguish as the parents, he cannot hope to be the one to help translate the anguish into constructive planning and action that brings relative serenity and comfort into the lives of the families facing this problem.

That this casework dilemma does exist is well illustrated by the frequency with which institutionalization is over-sold in view of the over crowded institutional facilities in this and other states. Examination of case records will show us that families often approach us only when the pressure and tension is almost unbearable and feel that they have exhausted every way they individually know of handling it themselves. At this point, the family would like to go ahead with no interruptions and get it over with immediately. It is as though, having finally come to the decision, the only way to ease the pain is to have the surgery done with no delay. The strengths and defenses that have gotten them through up until now always seem to have lost their effectiveness, and they sometimes seem almost helpless. Also, we usually find that the problems have been allowed to mount until the situation is very close to impossible in reality. In spite of this, it is very important that we share honestly with parents from the beginning just what the situation really is and approach the whole thing from the viewpoint of going into partnership with them to explore together just what can be done. By this I mean, saying early: "Mrs. Jones, I realize what a terrible situation you are in," going on to share with her just what conditions are for care and then working out together what can be done. This kind of approach can be cruel, however, unless running all through it, the caseworker is consistently kind and gentle and recognizes over and over again with the parent how tragic and painful all this is. It is quite true that in spite of this approach there will be many instances where immediate institutionalization will be necessary, but I suspect that there also are many where other temporary plans could be made or a waiting period better endured. In such an approach, commitment

and institutionalization become but two of several tools in what amounts to family case work around a specific problem, and the end result is infinitely more enduring in the peace and security that follows. It seems to me too, that this is an avenue to a far sounder community appreciation of the problem and should lead to increased public support for expansion of our facilities because of the more rational, less impulsive, feelings which are otherwise aroused and then later repressed when the deed is done.

And now, having looked at ourselves as the people who do this job, let's look at the job itself and see what that involves.

WORKING WITH THE PARENTS OF THE LOW-GRADE CHILD.

This part of the problem I am going to approach by presenting several principles for your consideration and, I hope, discussion.

The first of these has to do with diagnosis of mental deficiency. It is my impression that, generally speaking, the diagnosis will usually have been made before the caseworker is approached for help. This very fact has, however, some of the characteristics of a booby trap. Let us picture a parent coming to us and saying: "Dr. Brown has told us that our Tommy is a Mongolian idiot and that we should come to you to talk about getting him into Faribault." It would be very easy for us to assume that this, then, is the point where we and the parents start out together. Many times it will prove to be so, but before we can be sure of it, it will be wise to take time to find out what the parent really believes and understands about the diagnosis himself. There are a great many people who, out of respect and awe for doctors, will seem to accept recommendations given them without any question but down underneath may not really believe it or have many misconceptions regarding it. They may have been afraid to take the doctor's time to work these questions through or may initially have been too shocked to think clearly and have been wrestling alone with it since then. Into this category come, of course, such worries as heredity, what other children will be like, hope for change or cure where none is possible. In any case, our casework help will always be infinitely more sure-footed if we delay making concrete plans until we are sure the parents are really ready to go ahead. As many of you know from your own experience, we may otherwise suddenly find many obstructions appearing in the way, unexplained delays, broken appointments, or clients who seem to need to go over the same material interview after interview, never making any progress. Let us remember too, that it is the parent's right to reach these decisions on his own and in his own time -- it is only when a mentally deficient child is affecting or endangering others to a serious extent that we have a right to step in and insist on some better solution than the parents have so far provided.

Another principle I would like to consider is that in planning for the mentally defective child, we make every effort to work with both parents and with others significantly close to the child and the problems he presents. Unless everyone whose feelings are involved is carried along, plans can easily backfire because of the one who remains doubtful or resistant. Because mothers are usually more available for interviews than fathers, we often confine too much of our work to them. This is true in other kinds of casework efforts too -- foster home studies, for example -- and failure can often be traced to our not having extended our relationship and services to enough family members. In our Well Baby Clinic recently we had a dramatic example of this. One of the doctors did a fine job in helping a mother evaluate her child's lack of development and in enabling her to reach the point of being convinced of her child's mental deficiency. She left the interview feeling at peace for the first time in many months. That night the doctor's telephone rang at home, and he found himself talking to an angry, upset, father who had been left out of the process and was, therefore, nowhere near the point of accepting that his wife was. He was justified in being angry but more than that, we are

now faced with having much farther to go because the effect of the anger must now be overcome in addition to all that was difficult in the first place. At best, the decision to plan for a child out of the home is a very difficult one to make and maintain, and if it is constantly subjected to a barrage of doubts or criticisms from others whose opinion means a lot, we have not really helped enough. It will make even more unendurable the doubts that most parents experience when they see the child at the institution among all the other patients who are not yet children or people to the parents of one particular patient, or when the neighbors wonder about where the child has gone and come up with all their own advice and misconceptions, or when other children in the family, not old enough to understand, react with anxiety to the child's disappearance from the home.

Without identifying it directly, I have already referred many times to the difficulty and guilt that all parents experience when they think about and go through with plans to place a child away from his family. Before we go any further in talking about this, I want to emphasize that I am saying this to you as a group of professional people, to help in any way that I can to make your efforts more successful. What we say here, we must be clear, is only for your understanding and not to be used directly with parents. Most such parents are aware in varying degrees that this is an exceptionally painful experience but few, if any recognize that it is guilt along with other things like separation from the child that is making it so painful. It is important for you to know it for two reasons: 1) to realize what a profoundly painful decision it is to make and therefore to be patient and understanding of the time it takes to make it, and 2) to give parents something constructive to hang on to that provides a balance for this guilt: a real feeling that they are being good and generous parents in giving the child up to a place and people who can make him even happier than they; helping them to find ways of making the world a better place for all defective children or human beings underprivileged in other ways -- in short, finding an outlet that will be a relief against this thing that it is so hard to do.

This guilt is based on many things and varies in intensity with different people according to their life experiences. There is one certain thing about it, however; every parent experiences it. Our society places and always has placed a very high premium on the responsibility of a parent for his child. Failure to carry this out is always a source of great disturbance to a parent. It is not always openly and obviously expressed. Sometimes on the surface one sees attitudes of stony indifference, or brightness and cheerfulness that make it seem all is well, -- or more frustrating still, an attitude of neglect that would seem to imply just the opposite. Don't let these lull you into taking them at face value -- do all you can to help the parent come through to a more satisfactory adjustment to the problem but in doing so, never touch or try to tear down these defenses you see -- they are only the outer signs of the struggle he is having, and they wouldn't exist if the person didn't need them badly. They will disappear of their own accord when they have been replaced by something better.

The avoidance of technical or emotionally charged terminology in work with parents is a principle which you probably have had pounded at you a great deal already, so I will not dwell on it now, other than to tell a story that well illustrates the dangers. A mother who came to a child guidance clinic for diagnosis of her child's mental deficiency and who seemed to recognize it quite well, nearly faint when the social worker told her the child was "feeble-minded." When the social worker backed up to find out why it was so shocking, she found that to her the words "feeble-minded" and "idiot" were one and the same. This mother was prepared to expect some retardation but not in the degree the word meant to her. Use the most gentle and considerate words you can find and particularly use the parent's own words when you find out what they are and what they mean to him.

In recent years, there has been a trend towards removing the child from parents at birth if mental deficiency was recognized immediately. The

development of this trend was based on experience gained from seeing how hard it was for parents to part with a child whom they had grown to love through daily care. It has been a humanitarian move but I wonder and would like to have you consider with me whether it should be applied as a general rule without considering the individual parent and its meaning to him. Work with many parents after this has been done has revealed reactions which are far from desirable. It denies, in the first place, the attachment that grows up during pregnancy -- this is not a meaningless physical experience only. I think of one young mother, very intelligent and well educated, who acceded to such a plan and then was found to be peering into baby carriages all along the street, looking for her baby and needing to know if it was really as bad as the doctor said. She was helped by seeing the baby and going over, point for point, with the doctor how her baby was different. After that, she really could plan for him and feel secure that she was doing the right thing. With another mother, it was discovered about 4 years later and quite by accident that she thought her baby had been born without arms and with a hole in its head. Even though she had never mentioned her beliefs, she was greatly relieved even though the baby had died some time before this. I wonder, therefore, if consideration could not be given to some modification of this approach: presenting immediate separation of family and child at first on a temporary rather than irrevocable basis, thus, allowing for time to work out more permanent plans. Otherwise, it seems to me that the parents must decide too much too soon. We as caseworkers, I realize, are not the ones primarily responsible for what happens at this particular point in people's lives but later we are often the ones who test out what really happens, and I think we have a responsibility and contribution no other profession can make in making known what is and what isn't good about how things are done.

Still another suggestion for work with parents is that we not terminate our helping relationship before it is really over. Service-wise, the point of institutionalization would seem to be it. To the parents, this must seem too soon. I suspect that the day after the child is gone might easily be one of the hardest days of all. His absence is now a real fact, and the parent is full of such little worries as when to visit, how to plan further about clothes, etc. He may need to talk over once or twice again whether he has done right. He should be referred to the institution social worker, of course, but until that relationship is fairly well established, our job is not complete and may, indeed, be in danger of falling through if this last and necessary little bit of support is lacking. I would doubt if it need to last so very long or involve more than an occasional friendly phone call, not much for the busy worker, but a great deal for the parent.

As a last suggestion, I would like to consider for a moment the caseworker's potential working relationship with the public health nurse. In my present work in a health department, I have discovered that time and again the nurse in the performance of her regular functions is meeting and being appealed to for help by many of the same families you are. The need for close teamwork is imperative: the support and help can be twice as strong, the possibility of weakening by being played off one against the other, as two case workers often have been, will be much less. In addition, the nurse has skills in physical care and habit training, for example, that can do much to lessen the burden of the mother or boarding mother caring for such a child at home. As you know, the breaking point is reached by an accumulation of little things rather than one big one -- easier ways to give baths, help with diet, reassurance about a child's condition, all of these may prevent the break that you would give anything to avoid.

OWATONNA STATE SCHOOL

C. M. Henderson

The Owatonna State School is one of the cogs in a larger wheel that is designed to care for and educate the mentally deficient segment of the Minnesota population. The several types of institutions represent an attempt to break down the mentally deficient individuals into more or less congenial homogenous groups that can be trained and cared for more efficiently.

Session Laws 1947 amending Minnesota Statutes, 1945 247.14 Section 4 and 247.15 Section 5 defines the purpose and function of the Owatonna State School as follows: (247.14 Section 4) "The Owatonna State School shall be used as the state institution to provide academic education and vocational training for all those feebleminded persons who may through such education and training be prepared for return to society as self-supporting individuals."

(247.15 Section 5) "The Director of the Division of Public Institutions shall provide for admission to the Owatonna State School of those persons committed as feebleminded, who, in his opinion, may benefit from academic and vocational training and through such training and education be prepared for return to society as self-supporting individuals. When it may be determined by the superintendent that any individual admitted to the Owatonna State School will no longer profit by a continuation of residence there he shall be removed by the Director of the Division of Public Institutions and placed where he may be more adequately cared and provided for."

This function is further defined and clarified in the Manual for Welfare Boards published by the Bureau for the Mentally Deficient and Epileptic of the Division of Public Institutions, 1950, as follows:

"Children between the ages of 8 and 16 who have a mental age of 4 or more and an I.Q. of 50 or above are considered for training at the Owatonna State School provided they have no severe emotional or physical handicap or have exhibited no behavior which might make them a hazard to the other children. Whether a child who is past 16 will be accepted depend primarily upon how serious delinquent he may have been and upon whether he can profit from additional academic as well as industrial training. Severe spastics, children who cannot walk about unassisted particularly during icy weather, and children who are blind or deaf as well as mentally retarded are not eligible since there are no special facilities for their care. Since only children who are committed as mentally deficient are eligible, those with borderline intelligent quotients are not unless other factors have caused the psychologist or psychiatrist to make a definite diagnosis of mental deficiency. When the diagnosis is questionable, the Bureau for Psychological Services will be asked to give special consideration to a recommendation concerning commitment."

The Owatonna State School is only one member of team of three separate agencies that works to bring about adequate care, training and placement of high grade mentally deficient children. The County Welfare Board and the Bureau for the Mentally Deficient and Epileptics acting for the Director of the Division of Public Institutions form the other members of the team. Copies of all correspondence by any of the three agencies regarding a child at the State School or a child likely to be placed at the Owatonna State School are sent to each of the other two agencies.

Although only the higher grade mentally deficient children are admitted to the Owatonna State School all of these children are by no completely homogenous even similar in all respects. The general types may be classified as follows:

1. Children whose mental deficiency is complicated by emotional and personality problems.
2. Children whose environment is aggravating and producing undesirable social habits making necessary closer supervision than the child's home can provide. This group differ from one essentially in that the bad habits have not become deeply rooted and have not as yet become serious personality problems not correctable by a change of environment.
3. Children whose problems are primarily educational. These come from smaller communities where special educational facilities are not available for the mentally deficient.

To put our children into the exogenous and endogenous groupings would probably be a true classification but probably not specific enough for a clear understanding of the school's problems.

The more general objectives of the Owatonna State School are to provide a well rounded training program for its children through

1. The School Program
2. The On the Job Program
3. The Cottage Program

Moreover the School provides the close supervision necessary in the training of this type of child.

The School also provides a congenial community life which does not make greater demands on the child than he is able to meet.

Since it is not known ahead of time what types of jobs the boys and girls who leave the Owatonna State School will be placed in, it is impossible to train them for a specific job according to the New York plan. The specific aims in our training program therefore embrace the following skills:

1. Good Work Habits
2. Manual Dexterity
3. Personality qualities essential for adequate community living and for getting and holding a job.
4. Academic proficiency within the abilities of the children.
5. Ability to use spare time (recreation)

The areas that are used to produce these skills are as follows:

1. Cottage Program
 - a. Personal hygiene
 - b. Good house keeping
 - c. Group living
 - d. Spare time recreation
2. On the job training
 - a. Kitchen and dining room
 - b. Laundry
 - c. Farm and dairy
 - d. Gardening and yard work
 - e. Store room and delivery
 - f. Bakery

3. School Classes

- a. Academic
- b. Sewing
- c. Cooking
- d. Needle work and weaving and knitting
- e. Music
- f. Woodworking
- g. Printing
- h. Shoe repairing
- i. Crafts for little boys
- j. Farm training
- k. Power sewing machine on commercial basis
- l. Physical education

4. Contacts with the Community - An attempt is made to keep the children in as close contact with extra-institutional life as possible through:

- a. Summer vacations
- b. Scout Camp attendance by some of our boys
- c. Invitation of organizations such as Rotary Clubs to hold their meetings at the institution with selected children attending.
- d. Children attending certain activities in Owatonna such as movies, church, fair, etc.
- e. Correspondence with family and friends
- f. Visitors
- g. Junior Rotarian of Month (one of our boys attends Rotary every week for a month, then another is selected)

5. Religious Training

- a. Sunday services every Sunday for Protestant and Catholics
- b. Religious instruction one half hour per week
- c. Extra services and instruction for Lutheran children one night a week
- d. Infrequent attendance of churches in town by individuals or small groups

6. There is at this time no trained recreational director in charge of spare time activities though we hope to have a part time person on the job in the near future. Each cottage provides table games in the cottage during the winter and certain playground activities during the warmer weather. A skating place is provided in the winter. One of the physical education teachers has some square dancing activities during certain nights each week. A movie is provided each week. The school provides parties and dances during the year. There are also other miscellaneous recreational activities.

7. There is mingling of the sexes in most of the activities about the school. All school classes are co-educational.

8. There are no locked cottages and for the most part children are allowed to go about the school in much the same way they would be allowed to go about the community when they are at home. They go to and from school unaccompanied by an adult. Boys and girls going to and from their work are not accompanied. Boys and girls are not allowed to go where they wish any time they wish. They must stay on their own grounds unless there is a reason for their being elsewhere but the old institutional practice of marching children in lines everywhere they go is almost non-existent at the Owatonna State School. They go in groups accompanied by an adult when they go to evening activities.

9. Food - not only do the children eat the same food that the employees eat but they have table cloths and napkins and the food is served family style with an older child at the head of each table where six children eat. Their training in table manners is important we feel.

What are our needs?

1. Buildings. Several of our buildings are old and completely inadequate for efficient and comfortable housing of children.

2. Personnel. There is a great need for well trained people to care for the children. Particularly those children who have emotional difficulties.

3. A better understanding and acceptance of our children by the communities outside of the institution.

4. More school rooms.

What can the social worker in the counties do to help us?

1. Give us a good history for each child.

2. Read carefully the rules and general principles laid down in the Manual for Welfare Boards published by the Bureau for the Mentally Deficient and Epileptic of the Division of Public Institutions and attempt to observe those rules and familiarize the parents with them.

A REPORT TO THE BOSS

Ralph H. Rosenberger

One of the reasons why I was so delighted to accept your invitation to be at this annual meeting of yours is that it gives me an opportunity to indulge in a favorite American pastime - Talking Shop. It has always seemed to me that in any well-run business, men ought to sit down from time to time and talk things over with their boss. Now a lot of people may think that I'm one of the bosses of the Annex for Defective Delinquents, but of course, I'm not, in reality you are. You members of the organization of Social Welfare and your colleagues in this specialized profession are our principal stockholders. You are our principal customers, and so it is you and your colleagues who determine just what kind and quality of product we shall turn out. It is you that are responsible for our policies and objectives. You get all of our products and we as the Annex for Defective Delinquents exist to serve you and we shall continue to exist only so long as we serve you to your satisfaction. So you are the boss and my purpose in coming here this afternoon is to discuss with you some of our mutual problems.

Now our mental problems at the moment boil down to just one undeniable fact: you have had people in your community that could not adjust without Institutional Training and so you have sent them to us for retraining and we in turn are to send them back to you for social adjustment.

I'm here to discuss our program of retraining with you. Not to try to convince you that we have all the answers, but to sit down and talk shop with my bosses.

First, I want to tell you how we happened to get into the business. In July 1945, our population because of the war was low. We had room in our Institution, Fairbault was fairly bursting at the seams and over crowded. There was talk of building a new Institution, but this was not the logical time to build. So after looking around the legislature sat down and with a stroke of the pen designated us as the new Annex for Defective Delinquents. That's how we were born. A short time later the Director of Institutions came down and arranged for a transfer of patients to our Institution and we were launched in the business.

To say that we were lost and struggling in the dark is to put it mildly. You see we were sort of jarred out of our smugness and rocking chair complacency. To say that we resented this intrusion is a gross understatement. To say that we had many problems that needed immediate solving is again a mild statement. We decided that they couldn't do this to us, but they did. After sitting around and resenting for awhile a red letter day came along. That is the day the staff got together and decided to accept the challenge. We decided that we were going to have the best program that our physical facilities and our staff could possibly provide.

In one way we were at a disadvantage. We were starting from scratch. Our training program was not geared to a defective level. I believe that what started out to be a disadvantage finally turned out to be our biggest asset. We had no basis on which to start, but we also were not burdened with outmoded customs or traditions, that we had to live up to. We could do just about what we wanted to do. So we set about learning the business. Fortunately I was about to leave for California. While there, I had an opportunity to talk with interested professional people in the field. I came back with some ideas. Mr. Whaittier and I had an opportunity to travel to Boston and look over some of the Institutions that had been in the business for a long time. Along with some others we visited Napanock, in New York state, the largest Institution dealing with defective delinquents only, in the United States. Some of the things we saw we liked others we disliked. At any rate we were getting ideas. Meanwhile, we started attending your meeting on a County, State and National level, getting ideas. We visited with you people both in your offices and in our

Institution. We contacted the University, the State Department of Education, psychologists, teachers, psychiatrists. We got a tremendous amount of help from Faribault, Owatonna and Miss Thomson's office. We were reading the literature in your fields. We attempted to get both the theory and the practical picture.

From this our present program evolved. I don't suppose there is an original idea in our whole program. We begged - borrowed and stole our general objective our principles of procedure and our general organization from you and your colleagues. The only thing that I could credit our staff with, is the desire to meet the challenge and to end up with the best. Our motto is that we will try anything once.

I want to spend the few remaining moments rapidly giving you our major objectives and plan of organization.

COURSE OF STUDY FOR DEFECTIVE DELINQUENTS

INTRODUCTION

When using this plan, remember that the teaching of the fundamental academic skills is a secondary objective. The adult mentally retarded who become institutional cases are usually lacking in a social-moral sense. Ignorance of the fundamental academic skills is not the real cause of their difficulties. Therefore, the main objective is the awakening, training and strengthening of the patients' sense of social and moral responsibility.

The adult mentally retarded patients who have the ability are encouraged to seek out information for themselves by our making available to them pictorial stories, health literature, a simple and well-illustrated library and easy books on the regular academic skills. Sound judgment must be used in selecting reading material, for though many of the actions of the mentally retarded are decidedly juvenile, they resent any attempt to force on them literature which hints, however remotely, at "talking down" to them.

Though the emphasis is on those projects which inspire one with a respect for authority and the rights of other people, it must not be concluded that reading, spelling, writing and arithmetic are to be ignored entirely. These skills should be taught in conjunction with and as an outgrowth of the citizenship projects. Of prime importance and something which must be done before the teacher can expect adult mental patients to want to read, is to create a strong interest in the subjects which are discussed by the teacher. Constant repetition is the best assurance any teacher can have that his objectives are to be successful with the adult mentally retarded. Once the mentally retarded patients have acquired some knowledge of the subject being taught, through lectures and class discussions and life situations, they will have the motivation which is necessary for them to see the importance of gaining such skills as reading, writing and arithmetic. For example, when the teacher believes that his patients have a fair understanding of the necessity and desirability of budgeting their earnings, then would be the time to teach some simple arithmetic so that the patients have no cause to worry about the admission of arithmetic into their lives.

Much of the success of retraining mentally retarded adults depends on the intelligence, understanding and imagination brought into the program by the leader. At this course of study is merely a suggestive guide and does not begin to cover many possibilities within each general field. The staff, therefore, must be willing to expand each phase of this plan to bring out the desired results. The flexibility of this course makes it possible for the instructor to select for presentation whichever phase he believed to be pertinent and important to the instructing of his group at any particular time.

In conclusion we have been guided in organizing this plan by the belief that the major objective of any plan designed primarily for the retraining of the adult mentally retarded should be concerned with giving the patients a broader and clearer conception of their relationship to society. All projects, discussions and lessons should deal with actual life situations and, through proper guidance, should arouse in the patients a healthy attitude toward these situations. Through constant drilling and repetition of the desired reactions we hope to gain our objective, that is, an understanding of good and bad, right from wrong.

I. GENERAL OBJECTIVES OF PLAN

- A. To develop in the patient those traits important in helping the mentally retarded to make his way into the world a pleasant manner, well ordered habits of industry and persistence, care of ones' personal appearance, ability to get along with people.
- B. To acquaint the patients with basic health information, more important civic and social relations, and the proper use of leisure time. Citizenship, moral and ethical character, and worthy home membership are a few of the elements required for the social relations.
- C. Practical efficiency in reading, spelling, handwriting, and arithmetical computation is not a distinct objective in this course. Instead of being an objective related to some main aspect of life, as are health; social-civic efficiency; and worthy recreation; this is an objective dependent upon the degree of efficiency acquired in these main aspects of life.

II. PLAN OF PROCEDURE

- A. The interests, capacities and needs of the individual patients on an individualized basis are the determining factors for the specific classification and work placements.
- B. Participating in cooperative enterprises related to health, civic, social, occupational, educational and recreational activities are a must.
- C. Building habits and skills in reacting to life situations which will more or less become automatic forms of behavior is our ultimate goal.

III. SPECIFIC OBJECTIVES

- A. Health Education
- B. Personality Building
- C. Mental Health
- D. Citizenship
- E. Vocational Education
- F. Social Education
- G. Dignity of Labor

GUARDIANSHIP AS A BASIS FOR COMMUNITY SUPERVISION

Phyllis Mickelson

I. INTRODUCTION

My two themes.

I have often heard Miss Thomson remark out of the wisdom of her more than 26 years work with the mentally deficient: "The mentally deficient are just like other people; only more so." In many respects the same thing can be said of case work with the mentally deficient: it is just like case work with other people; only more so. Pointing out likenesses and differences too, will, therefore, be a recurring theme in what I have to say. Another theme will be how many, many fascinating and technical problems there are to challenge our wit and skill, whether we are working with an all mentally deficient case load or with a few such individuals as part of a more generalized load. Yesterday's panel discussion on who should be diagnosed and who should be committed as mentally deficient was a dramatic illustration of this, and Miss Kohlsaat and others on the program have opened the vista wide on many another problems awaiting our solution. Thus, my corrolary theme is that work with the mentally deficient is far too challenging ever to be dull.

Implications of Minnesota's program to county social workers.

First a word about Minnesota's social program for the mentally deficient since it provides the basis for what we are able and are expected to do. In most states the mentally deficient are committed directly to an institution, and when paroled, are supervised by social workers from the institution or from the central state office. When discharged from parole, all responsibility for their welfare terminates. Minnesota's program is significantly, and so far as I know, uniquely different. Since 1917 our law has provided that the local Probate Court may commit the mentally deficient, not to an institution, but rather to the guardianship of the state, at present to the guardianship of the Director of Public Institutions. Once established, this guardianship remains in effect for life, unless it is discharged by subsequent court action and gives to the Director authority to plan for the ward in whatever way he deems best: in the institution or in the community. The point which concerns us especially here is that although the mentally deficient are committed to the guardianship of the state, the responsibility for their supervision in the community remains by law that of the local county welfare board, and in all matters relating to the mentally deficient the welfare board serves as the local agent of the Director of Public Institutions. As a consequence, in Minnesota services to the mentally deficient have since 1917 been an integral part of the general social services given at the local level, and as a further consequence, county social workers in Minnesota have had the reputation, as a whole, of being more interested in the problems of the mentally deficient and of the resources for meeting their needs than has been true generally in other states, where a few social workers may know a great deal more than we do, but where the majority know, and have reason to care considerably less. Another strength of our program lies in the potential and frequently realized integration between the institution and the community that it makes possible. In the final analysis, of course, the success of either type of program depends primarily upon the people who carry it out; in this respect all programs are like the little girl with the little curl right in the middle of her forehead.

Guardianship law based on characteristics of mentally deficient.

It can be readily seen that the guardianship law is based upon the peculiar characteristics of the mentally deficient: (1) Since they are less able in varying degrees to look after themselves and are potentially more vulnerable to social failure, presumably they need someone to look after their welfare, to stand in loco parentis to them, so to speak; and (2) since the condition, if correctly diagnosed, is presumably permanent, guardianship is for life, unless it is discharged by subsequent

court action.

II. PROBLEMS WHICH THE CASE WORKER MUST MASTER UNDER THIS TYPE OF PROGRAM

What are some of the problems we all have to master in order to work successfully and comfortably with the mentally deficient under this type of program? Since these are problems which in varying degree are common and inevitable to us all, and problems which consciously or unconsciously all of the other speakers have already brought to our attention, I hope that no one will interpret any of my remarks in a destructive way.

The worker must learn to act as a responsible but creative agent.

First there is the problem of properly placing the focus of our activity and of finding our place in the scheme of things, in a program where responsibility is divided and where we must so frequently act as the agent of someone else. As Bertha Reynolds¹ has pointed out, this is as important to the case worker as proper placement of his voice is to the singer. Here the guiding principle is that the social worker is there to serve the client. State guardianship and the services it makes possible is one resource that he uses, and uses appropriately and creatively, we hope, to achieve this purpose. It is a tool, not a master, an enabling act, so to speak. By itself, it can accomplish nothing; it is the worker who makes it work, or not. Sometimes, however, it may confuse and overwhelm the worker, particularly the beginning worker, and he acts as though his purpose were to serve the state, rather than his client. He does not yet realize that so far as the entire program is concerned, he is the heart of the matter. At such a stage in his development, the worker is perhaps unconsciously overidentifying with the client and undervaluing himself. He probably unconsciously agrees with the client's definition of supervisor as "checking up", which without quotes he will later come to recognize as a legitimate function, when he is able to use it to some purpose. At this point, however, the worker apparently hesitates to make a home call unless it is specifically requested by our Bureau. If questioned by the client, he will probably reply that the reason for his call is that the state has asked him to find out for them how he is getting along. Invariably he will finish his report to us by stating: "We shall be happy to get more information for you if you desire". He does not seem, however, to regard supervision as a continuing and directing force in his client's life. Should any controversial issue arise, such a release from the institution or from guardianship, he is inclined to feel that since the individual is a ward of the state it is up to the state to decide. When operating on this level, it is, of course, very difficult for the worker to interpret forced institutionalization or any other authoritative action to the ward or to his family. It is something that "the state" is doing and about which seemingly neither he nor the client has any choice. Now it is true that the state as guardian does have the final responsibility for any action taken. Involved in this responsibility are such processes as getting all of the facts so that a fair decision can be made; actually making the final decision in any major matter, as for example, entrance to an institution; giving the welfare board necessary advice and help; and explaining and supporting the action taken to any interested individuals. It is equally true, however, that because of the way the program is set up the local social worker and the welfare board cannot really escape their share of responsibility. Their responsibility, for example, for securing the information on which commitment and institutionalization are initially based and later on which a vacation or trial release will also in part depend; responsibility for evaluating the information it secures and for making some type of recommendation; and also for dealing in some way with the final decision made, whether this consists of helping to explain why a request must be denied; attempting to work out some compromise plan; or actually helping to carry out the plan agreed upon. Actually of course, it is not a question of an either or but of a shared responsibility, in which there is need for much give and take at every point along the line. Furthermore, when we stop to think, we realize that this sharing of responsibility is act-

usually common to any type of social work that is practiced under agency auspices. In no agency does a social worker operate on an independent basis, responsible only to his client and himself. Always he has his supervisor, his agency, and the laws and policies which bind it. Thus we see that the ability to operate on an increasingly creative and independent level and yet at the same time as a responsible agent and under direction is really part of growing up professionally and of finding a proper balance between our dependence and independence on the job. The only difference is that under a guardianship program, the element of acting as the responsible agent for someone else is more dramatically apparent.

The worker should leave others free to carry their share of responsibility.

Unfortunately, in the process of trying to find their proper place, some social workers go to the other extreme and try to take too much responsibility, not only for their own behavior, but for other people's too. They identify themselves so closely with the client's needs that they seem unaware of anyone else's. It is surprisingly easy to fall heir to this sin, if not generally, at least in one or two favored cases. For example, the Court must commit Susie Smith. Susie must stop drinking. The minister and the parish must help Susie, etc. Now in order to live happily with himself and for others to live happily with him, the social worker must never forget that he is a catalyst, no more, no less, and that in the final analysis, it is the client who does or does not do better; the Court which does or does not commit, the community that provides or fails to provide needed resources or agrees or fails to agree with the action taken. At the same time it is true that social workers do have specific responsibility for calling certain problems to the attention of certain people, and for making information available to these individuals or agencies on which they may base their decisions.

The worker is always part of a team.

Under the so-called "new" mental health program we hear much talk of the clinical team; and in hospitals and other agencies where social case work represents a contributory rather than the primary service given, much attention is paid to defining the function of the case worker and of his need to develop skill in working cooperatively with others in the interest of the client. In all of these discussions, the county social worker need not feel the least bit left out. He too is every bit as much a member of a team, the only difference being that its participants usually come from outside his agency and that its membership is much more fluid and changing. Thus as we watch we see the social worker working now with the Court, now with the county attorney, the nurse, the physician, the teacher, the minister, the psychologist, the institution, a social worker from another agency, and always with the Bureau, sometimes with all these individuals simultaneously, and so on ad infinitum. Thus, in working with the mentally deficient one rediscovers another basic social work truth: to help the client we have to understand and work with many other people. Furthermore, since our essential skill supposedly is knowing how to facilitate human relationships, of all the members on the team, ours is the special obligation and duty to meet the other members not just half way, but all of the way if necessary to our clients' interests.

The worker must learn how to use authority.

Another facet of guardianship responsibility with which we must come to terms is learning how to use its authority comfortably and appropriately. Sometimes we approach social work as some parents approach parenthood; wanting only to say yes; never no; wanting only to give and never to limit or deny. If so, we will probably make like very much invoking the authoritarian aspects of guardianship: giving supervision to someone who does not seem to want it; institutionalizing someone vs his will etc. Unfortunately there are a good many things wrong with letting people do just exactly as they please, and particularly so, if the people involved are children or seriously unadjusted mental defectives.

Reasons why authority is needed.

The first objection is based upon practicality and common sense. One cannot be too worshipful of the principle of self determination, for when mentally deficient parents are neglecting their children, when retarded men or women are being sexually or economically misused, or when they are committing aggressive acts vs other individuals in the community and their behavior is not amenable to ordinary social treatment, the protection of the individual or of the community requires more drastic action. And usually with the high grade mental defective, it is just these cases that are referred. In this respect, work with the mentally deficient is based upon the same principles as is protective work with children and probation and parole work. One cannot work in any of these fields without developing a healthy respect and appreciation for the legitimate use of authority, particularly with individuals whose environment is so diseased or whose maladjustment so far advanced that it is sometimes necessary to break up the entire fabric of their lives and try to help them start anew.

Help, not "persecution".

In the second place, guardianship and the treatment it may impose is not an effort to punish the individual, as it is sometimes mistakenly interpreted, but rather to control and redirect the forces that are shaping and determining the individual's maladjustment. Without such authority, in many cases nothing would or could be done. Probably one reason people tend to feel so guilty about it is that the motive so often has been to punish the individual for causing so much trouble and to get rid of him. However, authority in and of itself is neither good nor evil, although it may be prone to misuse. Ideally, therefore, the authority imposed and the standards set by guardianship are not those of the worker personally and do not represent her personal whim or judgment, but represent rather those of the community of reality, so to speak. This again is true of case work generally, for always "It is the task of the case worker not to impose his own reality on the client, but to clarify with him the realities of living." ² Here again we see the worker serving as an agent, this time of the community, and here again we see social service in its generic function stepping in to try to help a specific individual make up for the environmental or personal lacks that are causing his difficulties. The methods used, however, are always tailored to fit the individual: that is what makes it case work.

Skill is required.

To begin with workers are also sometimes inclined to feel that since you can't make a person do anything he doesn't want to or is psychologically unable to, why try? Or what's the use of working with the mentally deficient anyway? Why not just institutionalize or sterilize them and free ourselves to do constructive work with more promising cases. Of course, if this is the way we feel, we probably won't try to do much of anything at all. We won't try to see if we can help mentally deficient parents to give their children better care, nor to prevent a delinquent girl from continuing to be promiscuous; a young man who is having difficulty with his employer from running away as he is threatening to do, etc. There are several things wrong with operating on this principle, the most obvious of which, as we shall see, is that it is actually psychologically unsound. Of course, it is also our job to try to help, and if we feel ourselves wanting, to seek out compensatory help. Furthermore, to give a client some help and then watch to see what he does with it is still the best diagnostic tool we have. Just because a person is mentally deficient we no longer can make an a priori judgment that he is beyond the pale of case work help. That is, if we have any case work skill, or want to develop any. As Charlotte White has written, "Skill is the art of dealing properly with certain situations" and "The skilled worker is endeavoring to meet the individual where he is in terms of his capacity to carry responsibility in any area whether it be in responding within the interview, expressing feelings, or initiating and effecting plans. The case

worker whosays that he can help only the individual who can use a certain kind of relationship is frequently saying that he can relate himself only to that individual who least needs help." 3 I thought Miss Blodgett emphasized this point very nicely.

Resistance to taking help is normal.

Furthermore, as we have studied the reactions of all sorts of people under all sorts of programs, we have gradually recognized the obvious fact that it is natural for clients who have managed to develop any degree of independence to show some anxiety and resistance in the process of asking for or taking help. Will he get the help that he needs? What price will he have to pay for it? Why does the social worker insist on his facing things that he would prefer to forget or deny? What will the neighbors say? etc. As Judge Underhill so repeatedly emphasized, a guardianship program gives the authority to take away large areas of a person's freedom and liberty. Small wonder that it may engender considerable anxiety. The mentally deficient may not be as capable of verbalizing these feelings or be as conscious of them, but experience indicates that they too are capable of feeling fear and generalized anxiety. We also know that different people have different ways of handling their anxiety, and so with this knowledge we have accepted as part of our job the necessity for dealing with the client's so-called resistance to treatment or defenses as treatment. How do we go about doing this?

How does the worker overcome the client's resistance?

In the first place, we give the client the opportunity to express his negative feelings. Unless he first gets his resentment off his chest, he can't proceed to go ahead and make the best of his situation. Unfortunately, in the process of growing up some of us may have learned too successfully how to repress our own negative feelings, in which case we may find it difficult to let the client express his. If so, we may get very anxious and think we must be or that others will think we are doing a poor job if our clients get angry or hostile. If we are in the know, however, we no longer call a client uncooperative because he expresses negative feelings toward us, although perhaps, we would still like to. And so, for example, when a high grade defective expresses opposition to continuing under guardianship and wants to "get out from under the state" and yet demonstrates a need for continued guidance, we would probably do best to acknowledge his resentment quite frankly with him, giving him permission so to speak, to feel disgruntled, and yet helping him to see, if only for the moment, that the reasons for it lie in his own behavior. If possible, however, he should be helped to see that the fundamental purpose of guardianship is to help him to overcome these difficulties, which is actually a positive and constructive drive. Thus, one does not permit nor necessarily accept his projection that all of his difficulties would disappear if only he could be discharged from guardianship. I was very glad to hear Dr. Delp emphasizing this point of the need for the mental defective to accept his limitations, and I suspect it will be a point that Mr. Hungerford will emphasize too, for it is so basic a part of his philosophy of training and placing and counseling the mentally deficient. Actually the primary purpose of the case work relationship is to provide the atmosphere in which this problem can be come to grips with. Before he can strengthen anybody else to face his limitation however, the case worker must be able to face it himself. He can't be scared of mentioning special classes, mental deficiency, guardianship and institutionalization, which I think yesterday's discussions brought out may still be big bogaboos in parents' minds and sometimes in the minds of other members of the team and perhaps even in our own.

The client should know what is expected of him.

We have also learned that trying to define with a client what we expect of him and what he can expect of us is another way to help reduce his anxiety at being dependent upon us. Thus if the client is bright enough to understand, he

should know that he is under guardianship and just what limitations and obligations this places upon him and what the consequences of his failure to meet these may be. The need for understanding applies equally to the parents of the low grade child who sometimes may experience considerable anxiety at the seeming loss of control that guardianship implies.

Rapport based on understanding; not lack of hostility.

In this connection listen to the comments of one psychiatrist upon the activity of many social workers: "A very sincere effort has been made to create a climate favorable to the establishment of rapport, but often the worker has not thought diagnostically and definitively about the client and his behavior. She has not asked herself what she needs to know about the client in order to be able to help him. Sometimes she does not realize that the maintenance of rapport is not based on lack of hostility to the worker but is established by the worker's tacit understanding of the basic problem of the client. Good diagnostic thinking does not threaten rapport." ⁴ As one successful application of this principle listen to this explanation given to a high grade girl just prior to a hearing in mental deficiency. Her parents brought her to the hearing, but stated in response to the worker's question that they had told her nothing about its purpose. The worker fortunately did not share their guilt and was able to give the following explanation: "After a few words of greeting in which worker told Mary that we have received good reports on her from the hospital and that apparently she was well liked down there, it was explained that we were going to ask that she be placed under state guardianship. When left to her own devices, it had been repeatedly proven that people took advantage of her and that in situations calling for judgment she was unable to make the best decision without advice. What we would like to do would be to help her in things like finding employment in the right type of home and advising her on any problem she might have in an attempt to help her get along better from now on. If we were not interested in her and in her friends we would not care enough to try to do this for her. Of course, no one could do anything if Mary did not help. During this time Mary sat there quietly with tears in her eyes and when worker suggested going into the hearing she came willingly enough."

How often we still fail to make guardianship work.

In Mary's case, it so happens that the high but also very individualized purposes of guardianship given to her in this explanation were never carried out. Mary had had three illegitimate children prior to being placed under guardianship; she has had three since. She is extremely anxious "to get out from under the state", but no effort has been made to explore with her why she feels the way she does and very little is actually known about her real adjustment. Proud as I am of the good work we do in the counties and in the state, I could not help but think during yesterday's discussion on commitment of the many cases like Mary's, cases in which, for one reason or another we really do not make guardianship work. Obviously, staff shortages and staff turnover are greatly to blame. Admittedly some clients are a great deal more difficult to work with than others. Clients and social workers alike are more comfortable when they avoid certain situations. However, as we become increasingly aware of what we can and what we should do for mentally deficient persons who have been committed to state guardianship, perhaps we can make better use of what time we do have, and thus more adequately carry out the intention of the law. Finally the worker must also recognize that resistance is generally recurrent, and so like a good teacher must accustom himself to repeating himself, particularly with the mentally deficient. We also must recognize that in a few isolated instances, resistance may be too extreme to be handled successfully, but also that in some cases the mental defective may accept his dependency unquestioningly.

Management of the case work relationship.

In concluding discussion of this second major point, to me state guardianship only brings home more strongly than ever that it is always the social worker's job to manage the relationship to some purpose. Presumably the social worker knows more than the client does about the conditions under which help can best be given; certainly it is his business to know; and therefore he does not permit the client, and particularly the mentally deficient client, to manage or control the relationship or to determine what is to be discussed and when. For example, when an individual is under guardianship, one does not sit back and wait for him to ask for help. Or when a report is received that a mentally deficient ward is planning to be married, and she replies that it is entirely her own business, the worker cannot just let the matter rest, particularly if the ward is not sterile. After all, the law does state that the mentally deficient shall not marry. Many of you know just exactly what to do and have done it many times; if not, I refer you to our Manual.

Use of authority with relatives.

The same principle applies to relatives and to other interested individuals. We do not permit them to determine what plans should be made for a ward, although certainly we try to give them every help in participating responsibly in the planning. If they cannot do so, however - for example, some may wish to place the ward out of rejection; others to secure his release out of guilt, for the work he can do; or out of lack of recognition or understanding of his condition; - we do not give in to their demands, but rather stand firm in whatever way is necessary in order to protect the best interests of the ward. Without the authority of guardianship, of course, there might be many times when we could not stand firm, and when, if persuasion failed, the wishes of others would predominate and control.

The mentally deficient usually need more help and for a longer period of time.

And now to consider briefly our third and so far as this paper is concerned, final problem: the greater degree and longer period of dependency which these individuals generally require. For the low grade this is the essence of the problem he presents to his family and to the community: his permanent dependency. For the high grade the degree of his dependency will depend increasingly on other factors. When workers are not sufficiently aware of this essential difference, they may repeat the error that is generally causing the mental defective's problem: that of setting too high standards and of becoming impatient and rejecting at the client's inability to meet them. Certainly, it is wrong to encourage dependency, but it is equally foolish to refuse to recognize its existence. Refusing to meet a person's actual dependency needs will only make him more helpless, not less.

Guardianship may be a life long protection for the severe retardate.

In this respect, some workers are inclined to be too quick in their desire to terminate guardianship. They will recommend, for example, discharge of guardianship for a child or adult of idiot or imbecile intelligence whose parents are satisfactorily caring for him and who do not desire institutionalization, on the basis that no particular service is required. Oftentimes problems do exist if the worker had the time or skill to recognize them. After all, a person who is differently abled usually creates some type of problem within the family group. Furthermore, no parent or relative of a seriously defective person can help but feel anxiety for his future. In such cases guardianship has a primarily protective function; it is like taking out an insurance policy. For the present it gives to such families the psychological support and concrete help they so often need: someone with whom to share their problem and with whom they can periodically consult. For the future it

gives them a feeling of security based on the knowledge that should anything happen to them or an unforeseen emergency arise, the state would have the responsibility through the local welfare board for seeing that some plan was made. For seriously defective individuals who by their nature will always remain permanently dependent, this is an important consideration.

Guardianship protects the high grade defective too.

In the case of the high grade mental defective, continued guardianship may serve a similarly protective function. Even though such a ward were getting along very well indeed, we would hesitate to take the initiative in petitioning for his discharge from guardianship if he were a single unattached individual, and particularly so if he were not sterile, or if he were a parent with children still to rear or a married person still within the child bearing period, for should circumstances alter, or responsibilities increase, it would be expected that such individual's adjustment might seriously deteriorate. In this connection we must remember that except for the severe defective, the I.Q. level is not the sole nor the primary determinant of the individual's adjustment; if it were, all individuals with I.Q.'s below 75 would automatically require supervision for their own or the public welfare. Rather social adjustment for the moron depends equally upon many other factors including his personality structure, the circumstances under which and the people among whom he lives, and the responsibilities he is expected to assume. For example, a mental defective in special classes might be a success; in the regular grades a failure. A mentally defective parent with one child a good parent; with 7 children a poor one, etc. Thus how much a high grade ward will need to depend upon us and for how long will depend as much upon these social factors as upon his relative I.Q. And so some of the borderline individuals will actually make the poorest adjustment of all. On the other hand, with many of the morons, marriage to the right person, a suitable job; increased income; living with dependable people who take an interest in them; a period on institutional training; or just plain growing old will greatly stabilize them, and so, many such individuals do not actually require supervision for the rest of their lives. Usually, however, the worker can anticipate carrying such cases for a longer period of time than would be true of case work with brighter people. The worker who requires frequent change may chafe under this necessity, although from the point of view of the client continued dependency may actually represent a very successful adjustment for him, and one which should therefore be satisfying to the case worker too.

Avoid encouraging unnecessary dependence.

At the same time when working with the high grade mental defective, as with any handicapped group, it is as important to avoid falling into the opposite error: expecting too little, rather than too much and doing for certain individuals what they could better be taught to do for themselves. This is a point to be watched especially with the young adult ward whose habits may still be somewhat malleable and whose life responsibilities may be relatively lighter. The family case, for obvious reasons, is the type which more often requires "interminable" treatment: one certainly can never withdraw until the children are grown or planned for satisfactorily.

III. CONCLUSION

By this time, if not heretofore, it should be obvious to everyone that case work with the mentally deficient makes just as heavy and as high demands upon the case worker as does work with people who are more intelligent. Here too we find endless variety in the type of problem presented and in the individual's reaction to it. We work with all degrees of mental retardation, and even with a few cases of mistaken identity. Many of the client's relatives are mentally deficient; many more are not. Also, here too we find all of the basic problems of social case work:

helping the client to accept his problem; helping him to take and use help; establishing his eligibility for the particular service offered; managing the relationship to some purpose and toward some end; working cooperatively with others interested in the client's welfare; not making the client any more dependent than he needs to be; meeting the problem of limited or insufficient resources and helping the client to do the same; the problem of termination of treatment, etc. Special knowledge about the characteristics of the mentally deficient and of the resources for meeting their needs is obviously essential. However such information is easier come by than skill in human relationship. We all know that the hard part of our jobs is the need to use ourselves consciously, purposefully and discriminatingly as an instrument to meet our client's needs. This is what takes the skill, the discipline, and self-control, the ability to think analytically under pressure; the courage to differ and to hold to a point despite opposition if it is in the client's best interests, the ability to deal helpfully with the very hostile, the very dependent, the very demanding, and the very ambivalent client, and never to take anything personally.

At the same time, unfortunately, it is not always recognized that to meet their client's needs social workers have to have some of their needs met too. And so, our case loads may be too heavy; working conditions within the office unsatisfactory; we may have many other problems and programs to master; others do not always nicely cooperate as we would like them to; demands are not always nicely timed to our ability to meet them; our supervisor or the social worker in the Bureau does not always give us the help we need, etc. And so there are times when all of us probably long for a nice simple monotonous job where we could perform the same repetitive operation over and over and which would have absolutely nothing whatsoever to do with people or their problems.

On days when we are feeling stronger, however, if we like social work, we just can't help like working with the mentally deficient. And so,

".....
 These possessions of a simpleton being the three I choose
 And cherish.
 To care,
 To be fair
 To be humble.
 When a man cares he is unafraid.
 When he is fair he leaves enough for others
 When he is humble, he can grow.
"

Laotzu⁵

REFERENCES CITED

- 1 Reynolds, Bertha. Learning and Teaching in the Practice of Social Work.
New York: J.J. Little and Ives Co., 1942.
- 2 Hamilton, Gordon. Psychotherapy in Child Guidance.
New York: Columbia University Press, 1947. page 147.
- 3 Babcock, Charlotte G., M.D. "Observations on Consultative Experience".
Social Service Review, September 1949.
- 4 Towle, Charlotte. "Underlying Skills in Social Case Work."
Proceedings National Conference of Social Work, 1941, page 254;
also in Social Service Review, September, 1941.
- 5 Bynner, Witter. The Way of Life, according to Laotzu.
New York: John Day Co., 1944. page 68.

FOLLOW-UP OF PLACEMENTS FROM INSTITUTIONS

Frances M. Coakley

How successful are the placements made from our institutions for the mentally deficient and epileptic? What are some of the factors that should be considered in determining the suitability of the ward for placement? What can those of us who are making community placements do to increase the success of our placements? These are the questions we in the Bureau for the Mentally Deficient and Epileptic have been asking and which I will consider in this follow-up study.

I would like to make it clear that this study is not as complete or comprehensive as I would desire, but it is as complete as it could be with the material which was on file from the county welfare boards. For most of the wards there was a report within the past year, but where no recent report was on file, the evaluation was made on the basis of the last report. I assumed that "no news was good news". The findings will differ somewhat from those presented by the Director of Public Institutions in his Biennial Report since I have used all information which was available through October 25, 1950 regarding these wards.

The group studied were all committed wards of the Director of Public Institutions and included all of those wards who had been placed outside the Minnesota School and Colony, the Owatonna State School, the Annex for Defective Delinquents, and the Cambridge State School and Hospital between the period from July 1, 1946 to July 1, 1948. This particular period of time was chosen, since we wanted to have a fairly long period since the placement to determine the wards adjustment in the community. All of those who were restored to capacity or who had died were eliminated from the study; therefore, this study includes only those who are now under our guardianship. It does not include those who ran away from the institutions and subsequently were discharged from the institution records. It is important for us to remember that there are significant differences in the four institutions studied, in the institutional population, and in the purposes of those institutions. This must be kept in mind since these differences are of importance and the various institutions cannot be compared one with another without recognizing these differences. In considering the data which is presented it is important to remember that the Minnesota School and Colony is composed of varied groups of all ages and degrees of retardation except that there are few wards under twenty-one years of age who have I.Q.'s above 50, that the Owatonna State School has only children of moron mentality from eight to twenty-one years who may be trained to be self-supporting, that the Annex for Defective Delinquents is composed primarily of men over eighteen years of age who have been seriously delinquent, and that the Cambridge State School and Hospital has wards whose main problem is epilepsy although many of them are also mentally deficient. The basis for this report is solely the reports sent in by the county welfare boards who are supervising the mentally deficient and epileptic wards. This study may serve as an example of one of the ways in which the reports which you send in are used and may show that we try to use those reports as a basis for planning for the mentally deficient of the state of Minnesota and to evaluate ways by which we may help you to more satisfactorily supervise our wards.

The number of wards who were included in this study was 147. Of these we have the following breakdown of placements from the institutions in this period:

Minnesota School and Colony	84
Cambridge State School & Hospital	35
Owatonna State School	12
Annex for Defective Delinquents	16

Since the Owatonna State School was not established as a school for mental-deficients until July 1, 1945, its number of placements was small.

In making this study quite a large number of factors were reviewed; however, since many of the county reports were meager in certain areas I was not able to analyze all of the factors that I would have liked to. Some impressions, however, were gained through this analysis which also will be given to you. The following items were recorded on each case: Name, case number, age, I.Q. range, years in institutions, sex, county, why ward was placed out and who took initiative in placement, present status, type of employment, resources utilized in community, and living arrangements. Most of these factors were broken down into rather broad classifications and coded. Since the classification, present status of the ward, was most significant, you may wonder what classifications and criteria were used. The cases were coded as follows: returned to the institution, adjusting well which meant that the ward was causing no trouble in the community or to his family, questionable adjustment where ward was unstable or had been disturbing in the community, and lost or out of state.

You will note that there are many factors which influence a placement which we have not considered. Undeniably such things as the cultural pattern of the family its economic status, its attitude toward a less capable member of the family, the personality structure of the ward, his motivations, his background of training within and outside the institution, his reaction to authority and supervision, and the degree of supervision provided for him in the community, plus many other factors are parts of the total placement picture which are important, but to which we did not specifically direct our attention to this study.

In determining the percentage of unsuccessful placements I found that the following number and percentage of wards had been returned to the institutions:

<u>Institution</u>	<u>No.</u>	<u>Per Cent of Institution Placements</u>
Minnesota School and Colony	9 or	11 per cent)
Cambridge State School & Hospital	6 or	17 per cent)
Owatonna State School	2 or	17 per cent)
Annex for Defective Delinquents	6 or	37 per cent)
		23 or 16 per cent of total placements

It is not surprising that the highest percentages of returned wards was from the Annex for Defective Delinquents. Two points regarding the Annex should be kept in mind. First that the Annex is the only institution with the policy that a ward may be returned at any time that his adjustment is unsatisfactory and secondly that its population is composed of seriously delinquent men who have built up over a long period of time a socially unacceptable mode of behavior.

It may be of interest to know the reasons for reinstitutionalization. From the Minnesota School and Colony two were returned as illegitimately pregnant one of whom was a woman of imbecile mentality who was released from the institution against the judgment of all agencies when her commitment was found invalid on the basis of Bernetta Wretling Decision, one was promiscuous and neglected her children, three had personality difficulties showing in moodiness, insubordination on the job, and fighting with family members, one who was involved in larceny had received little supervision either by his family or by the agency, one employed man of imbecile mentality was returned since he was generally inadequate, and one low grade child was too heavy for family members to lift and care for in the home.

All but one of the Cambridge placements were reinstitutionalized for medical reasons. Two were placed in hospitals for the mentally ill and the four other wards and their families all requested rehospitalization to secure the necessary medical care for epilepsy which was not available in the community.

The two placements from the Owatonna State School who were reinstitutionalized were both girls, one of whom was illegitimately pregnant and one who was picked up for vagrancy and promiscuity.

Of the placements from the Annex for Defective Delinquents three showed personality difficulties expressed in sullenness and inability to conform to supervisory requirements, two reverted to alcoholism, and one who was returned was generally inadequate, however, he had not had the benefit of careful supervision by the county welfare board.

Of those who were adjusting satisfactorily in the community I found the following number and percentages:

<u>Institution</u>	<u>No.</u>	<u>Per Cent of Institution Placements</u>
Minnesota School and Colony	51 or	60 per cent)
Cambridge State School & Hospital	26 or	74 per cent)
Owatonna State School	4 or	33 per cent)
Annex for Defective Delinquents	5 or	31 per cent)

Of those who were making a questionable adjustment I found the following) 10

<u>Institution</u>	<u>No.</u>	<u>Per Cent of Institution Placements</u>
Minnesota School and Colony	14 or	17 per cent)
Cambridge State School & Hospital	2 or	6 per cent)
Owatonna State School	5 or	42 per cent)
Annex for Defective Delinquents	2 or	12 per cent)

You may want to know some of the major problems of those who were making questionable adjustments. Of those from the Minnesota School and Colony we can classify the problems as follows:

<u>No. of Wards</u>	<u>Major Problem</u>
3	Transient mode of living, instability
3	Drinking
2	Sex
2	Rejection by parents with resulting family friction
1	Neglect of children
1	Unstable employment record
1	Involved in peddling of stolen goods
1	Low grade child - banging head, biting others

Owatonna State School

<u>No. of Wards</u>	<u>Major Problem</u>
4	Sex
1	Lack of initiative on job and neglect of personal care

Cambridge State School and Hospital

<u>No. of Wards</u>	<u>Major Problem</u>
1	Drinking
1	Difficult disposition (due to inability to compete with those of his own age)

Annex for Defective Delinquents

<u>No. of Wards</u>	<u>Major Problem</u>
1	Instability
1	Inability to manage his money

Fifty-eight per cent making a successful adjustment is not an impressive percentage and indicates that there is much room for improvement in our planning and supervision of wards who are placed in the community after a period of institutionalization.

Even if we combine those who were adjusting satisfactorily and those making a questionable adjustment we find that there would be 109 wards or approximately 74 per cent who were making a fairly adequate adjustment in the community.

Shimberg and Reichenberg ¹ who reported on a study of 189 defective children studied by the Judge Baker Foundation of Boston over a five and one-half years period reported that "the factor of supervision was found to be important. Sixty-six of the 71 cases with good supervision succeeded and only 9 per cent failed."

A very small number were lost or out of the state. This may be broken down as follows:

<u>Institution</u>	<u>No.</u>	<u>Per Cent of Institution Placements</u>	
Minnesota School and Colony	10 or	12 per cent) 15 or 10% of total placements
Cambridge State School and Hospital	1 or	approx. 3 per cent	
Owatonna State School	1 or	8 per cent	
Annex for Defective Delinquents	3 or	19 per cent	

¹ Shimberg, Myra E. and Reichenberg, Wally. The Success and Failure of Subnormal Problem Children in the Community. Mental Hygiene, 17:451-465, 1933.

Before reviewing the cases of those who were lost or out of the state it was my belief that perhaps many of these wards were lost since there had been little supervision in these cases; however, only three of these fifteen cases showed lack of supervision as the reason for loss of supervisory opportunities. Of the Faribault placements one of the women who was lost had made a very unsatisfactory adjustment in the community and little constructive help had been given to her. She realized that reinstitutionalization might be considered and disappeared from a relatives home. In one case where the woman is lost there had been very close supervision; however, relatives in a distant part of the state had been upsetting her for some time and it may be that she had gone to one of their homes. Another of the lost wards had gone with her husband presumably out of the state to secure better employment. The other five from Faribault all were in other states where, according to relatives, they were making a satisfactory adjustment.

One ward from Cambridge went to Wisconsin with the approval of authorities from that state to live with his parents.

One from the Owatonna State School is steadily employed on ore boats in the Great Lakes with his headquarters in Michigan.

The two placements from the Annex for Defective Delinquents whose whereabouts are unknown, are one man who was threatened by the local agency with return to the institution for non-support of his children and one who ran away from his work placement after expressing resentment over guardianship and supervision. In addition one ward is now in South America working for a shipping company.

I was interested in determining whether there was any relationship between age and successful placement.

Group Returned to Institution.

	Age Group	Faribault No.	Cambridge No.	Owatonna No.	ADD No.
1.	Under 5				
2.	5-16 years				
3.	16-30 years	3	4	2	3
4.	30-60 years	6	2		3
5.	60 and over				

Group Adjusting Well

1.	Under 5				
2.	5-16 years	3			
3.	16-30 years	20	12	4	4
4.	30-60 years	27	11		1
5.	60 or over	1	3		

Group with Questionable Adjustment

	Age Group	Faribault No.	Cambridge No.	Owatonna No.	ADD No.
1.	Under 5				
2.	5-16 years	1			
3.	16-30 years	6	1	5	2
4.	30-60 years	7	1		
5.	60 or over				

Group Lost or Out of State

1.	Under 5				
2.	5-16 years	1			
3.	16-30 years	3	1	1	1
4.	30-60 years	6			2
5.	60 and over				

It would appear that age seems to have little significance although probably it is more difficult for the older ward to adjust to community living. With the Owatonna State School we have a much younger group than from the other institutions and it is likely that this group is in the less stabilized age range than those of the other institutions.

I wondered whether the level of mentality was related to success in placement.

Returned to Institution

	Faribault No.	Cambridge No.	Owatonna No.	ADD No.
Idiot				
Embecile	4	1		
L G Moron (I.Q. 50-60)	3	1		2
H G Moron (I.Q. 60-70)	2	2	2	1
Borderline (I.Q. 70-85)		2		2
Dull Normal (85 and above)				

Adjusting Well

Idiot	2
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2. Imbecile	17	1		
3. L G Moron (I.Q. 50-60)	16	4	2	2
4. H G Moron (I.Q. 60-70)	10	2	1	1
5. Borderline (I.Q. 70-85)	5	5	1	2
6. Dull Normal (85 and above)	1	4		
Undetermined		10		

Questionable Adjustment

	Faribault No.	Cambridge No.	Owatonna No.	ADD No.
1. Idiot				
2. Imbecile	2		1	
3. L G Moron (I.Q. 50-60)	5	1		
4. H G Moron (I.Q. 60-70)	7	1	1	1
5. Borderline (I.Q. 70-85)			2	1
6. Dull Normal (85 and above)			1	

Lost or Out of State

1. Idiot				
2. Imbecile	1			
3. L G Moron (I.Q. 50-60)	4			2
4. H G Moron (I.Q. 60-70)	3		1	
5. Borderline (I.Q. 70-85)	2			
6. Dull Normal (85 and above)				

Because of the nature of the institutions the Minnesota School and Colony had most of the reinstitutionalizations from the imbecile and low grade moron group, and Cambridge and Owatonna from the high grade moron and borderline groups. The ADD showed scatter from the low grade moron to the dull normal groups. In the group with questionable adjustments the largest number are high grade morons or brighter.

Next may we consider the relationship of number of years of institution-ization to the success of placement.

Returned to Institution

Years In Institution	Faribault No.	Cambridge No.	Owatonna No.	ADD No.
Less than 6 mo.	2			
6 mos. - 1 year				
1-2 years	1	1		
2-5 years	2	1		2
5-10 years	3	3	1	2
10-20 years	1	1	1	2
20 years and over				

Adjusting Well

Less than 6 mo.	7	3		
6 mos. - 1 year	3	5	1	
1-2 years	6	3	1	
2-5 years	10	5		
5-10 years	17	7	2	
10-20 years	5	3		4
20 years and over	3			1

Questionable Adjustment

years in Institution	Faribault No.	Cambridge No.	Owatonna No.	ADD No.
1. Less than 6 mos.	4			
2. 6 mos. - 1 year	1			
3. 1-2 years	3		1	1
4. 2-5 years	6	1	1	
5. 5-10 years		1	3	
6. 10-20 years				1
7. 20 years or over				
Lost or Out of State				
1. Less than 6 mos.	1			
2. 6 mos. - 1 year	1			
3. 1-2 years				1
4. 2-5 years	5	1		2
5. 5-10 years	2			
6. 10-20 years	1		1	
7. 20 years and over				

Of those returned to the institutions more than twice as many has been institutionalized for over five years than for a shorter period of time. The largest number of those adjusting well had been institutionalized from two to ten years. It was interesting to note that of those making a questionable adjustment from the Minnesota School and Colony that four had been institutionalized for less than six months and that no one in this group had been in the institution for over five years.

In presenting the analysis of the relationship of success in placement to the reason for placement, who took the initiative in securing a placement, what living conditions seemed most desirable, and to the resources utilized in the community I am not presenting the tabulated data since I found that it was difficult to formulate clear out categories. For instance, the initiative for placement was often taken almost simultaneously by the family and the institution, the county welfare board or the Bureau for Mentally Deficient and Epileptics. The material presented in the rest of the study is therefore an observation or conclusion based on the study of these cases.

One of the most significant findings of this study was that the largest number of those who had returned to an institution had remained in the community following a vacation rather than through placement with a carefully formulated plan. These wards frequently suffered from lack or lapse of supervision, return to the same unsatisfactory environment (both emotional and physical) as before institutionalization, lack of preparation to meet community responsibilities, and lack of interpretation of ward's assets and liabilities to his family and the community. This indicated to me that the county welfare boards and the Bureau for Mentally Deficient and Epileptics must be more careful in making sure that a satisfactory plan has been made before the ward is released from the institutional rolls following a vacation.

In most of the cases the initiative in requesting placement was taken by the family. This may be expected; however, it seems that cooperatively the institutions, the Bureau, and the county welfare boards have the responsibility of securing a placement for the ward when he is most ready for that placement and when reasonably satisfactory plans can be worked out in the community. In the community it means securing the most wholesome environment suited to the needs of this particular individual with consideration of the total environment - the living conditions and atmosphere, employment, recreation and social life, religion, health, and understanding and acceptance of his differences and disabilities.

Most of the wards who were either returned to the institution or were making a questionable adjustment were living in their own homes. Of those successfully adjusted about one-third lived in work homes, rest homes, hospitals, or relatives' homes. To social workers this should be a significant finding, and I believe we can emphasize that institutionalization and training alone cannot assure a successful adjustment. In many cases the ward found it difficult to adjust since he was returned to the same environment which had contributed to his difficulties prior to institutionalization. It also brings to our minds the fact that relatives can play a constructive part in a ward's rehabilitation, contributing to his emotional security, acting as a source of control in his behavior, and helping the ward feel a part of the community.

Relatively little information was available in our records regarding the resources utilized in the community although the church was mentioned most frequently. Other resources mentioned were the movies, medical agencies, special classes, county commissioners, county agents, service clubs, and employment agencies. Frequently throughout the records there were notations that many of the wards had a difficult time in finding leisure time activities and acceptance in social groups. It may be that our training programs in the institutions may prepare our wards for leisure time activities and hobbies.

From this study I have made the following observations and conclusions:

1. There is a real need for a carefully formulated placement plan, including determination of readiness for placement and preparation of the ward and his family for such placement.
2. A conference at the institution for institutional personnel and case worker to consider placement possibilities may bring more understanding of ward and his needs.
3. Care and intensive supervision during the first year following placement is imperative. Ward must understand his status as a ward, his relationship to the county welfare board and his case worker, and his responsibilities as well as the services that the county welfare board can offer him.
4. Need for more interpretation of the ward's assets, liabilities and idiosyncrasies to those to whom he will be responsible either in his home, at work, or at play.
5. Need for more utilization of community resources to help the ward become a well integrated and useful part of the community.
6. Much fine supervision is being given in budgeting, but many wards still need additional help.
7. Need for more study of what personality factors and motivations contribute to successful adjustment.
8. Many wards with long periods of institutionalization had difficulty adjusting to the community, and for some several trial placements were necessary before they were successful.
9. Far too often employment was left to the ward and his family with little help interpretation from the agency.

We hope that with increased understanding of the mentally deficient on the part of all of us that our wards and the community will find us increasingly helpful and that we will strive to consistently raise our level of service.

TRENDS IN THE TREATMENT, CARE, TRAINING, AND
UNDERSTANDING OF THE MENTALLY DEFICIENT

Richard Hungerford

Many people confuse mental deficiency with conditions arising from lack of proper diet, lack of emotional security, or physical handicap. Actually mental deficiency is a physical handicap; but, unfortunately for the victims, it is a handicap which ordinarily cannot be seen. Technically a mentally retarded person is one who, because of mental defect existing from birth or from an early age, is

- a. incapable of profiting from ordinary schooling, and/or
- b. incapable of managing himself and his affairs with ordinary prudence.

This definition sets up four main qualifications of mental deficiency. First of all, it is a mental defect. In other words, it is a physical disability within the cells of the brain. Secondly, it arises at birth or at an early age. In other words, it is not a decline from something already existing, such as insanity is, but rather an incomplete development, which probably had occurred before or during birth or certainly within a short time thereafter. Third, all mentally retarded individuals are incapable of profiting from ordinary schooling, being they are among those who, at age fifteen will be unable to read with interest and with profit at a sixth grade level. Not all, however, who are non-academic are mentally retarded. Rather, it is only those who will be unable to do sixth grade work at age fifteen because of mental brain defects. Fourth, some, although comparatively small number, of the mentally retarded, never will be able to manage themselves and their affairs with ordinary prudence. These last are called the feeble-minded.

There are many groups of the mentally retarded. In former days they were classified according to degree of disability. At the lowest level were the idiots, those who at maximum would not have a mental age of more than three years and who always would be unable to guard against physical danger. The second group were the imbeciles with mental ages from three to seven. These might get around, might perform simple tasks, but for their own protection ordinarily would need permanent custodial care. The third group were the morons with mental ages from seven to twelve and with I.Q.'s from 50 to 75. The fourth group were the borderlines with I.Q.'s roughly 75 to 85. Some of the last group could profit from a modified regular school program. All, with special education, could be made independent or, in other words, able to get along without supervision as adults provided they had special education as children.

We now are inclined to think that a prognostic set of gradations is better. In other words, we now are trying to look at the mentally retarded in the light of what they will be able to do in society. Again at the lowest level we find a group who always will need custodial care. These constitute, we now think, roughly one-third percent of the total population. Next to these are a group, constituting approximately two-thirds of one percent of the population, who are unable to work in private competitive industry, yet can maintain themselves in part if sheltered workshops are available. (Unfortunately at present there are no sheltered workshops for this group.

The third group of the retarded are those who, if they have different or special education as children can maintain themselves in private competitive industry as adults with a reasonably small amount of supervision. This group constitutes approximately two percent of the total population. Above them are another four percent who only are in need of special education as children.

Although there are many variations among the mentally retarded, there are certain general attributes. First of all, a weak mind is not accompanied by a strong back. Rather, the mentally retarded child in general has about two-and-one-half times as many physical disabilities as does his normal brother. In addition, in spite of popular opinion, the muscular coordination of the mentally retarded is inclined to be markedly less than that of the normal. In appearance, with the exception of certain clinical cases, the difference is not as striking. There is no such thing ordinarily as being able to spot a mentally retarded person, and, as has been mentioned earlier, this in a way is an added handicap to the retarded because it keeps them from getting sympathy from the public as do the crippled, blind, and deaf. With respect to sexual development and drives, it can be said that, generally speaking, these are less strong with the retarded than with the normal. There are glaring exceptions, of course; but, generally speaking, it is not an over-development of sexual drive that causes the mentally retarded to get into trouble with the law but rather a lack of judgment. Thus, as Cyril Burke has pointed out, mental retardation is a permissive factor in delinquency. If the occasion presents itself, the mentally retarded will not be as liable to refrain. It is a car with poor controls; but the car itself does not have high horse power.

The mentally retarded child is roughly five times as liable to have some kind of emotional trouble as is the normal. Yet it should be remembered here that this still means that ninety percent of the mentally retarded will not get into emotional difficulty. In fact, among the mentally retarded will be found all states of temperament, all states of adjustment to society as far as outward behavior goes. However, there will be more at the two ends of the line. There will be more who will be maladjusted and there will be more, who, through lack of worry, will be comparatively more happy than the normal. This perhaps is an important thing to remember. The mentally retarded are different. They will have a different happiness pattern; and it is not kindness to them to attempt to fit the pattern of happiness of the normal to the life of the retarded.

With respect to academic attributes it should be remembered that there is a distinct top to what the retarded may be expected to do. At most, they will not do above sixth grade work. The overwhelming majority will do work between the third and the fifth grade. However, there are many among the normal who do not read voluntarily, irrespective of their abilities, above the fourth grade level. If this is doubted, note should be made of the number of comic books bought and read. More important to remember of this score is the fact that a mentally retarded child should not be started on reading or arithmetic until his mental age is approximately that of a six year old normal. Otherwise, permanent blocking or frustration may result.

In working with the retarded we often find they may have appeared to have mastered a given academic task only to have no concept of it on the following day. This is not an absence of ability to master the academic but rather an irresponsibility with respect to such mastery that characterizes them. Basically, mental retardation implies a lack of judgment, a lack of ability to adjust, a lack of ability to see cause and effect. From this it can be seen that, although a cliché, it is true that the hope of the retarded is habit.

The vocational attributes of mental retardation are not less pronounced. In the main, the retarded will not work above the unskilled level. On the other hand, even here they will find many competitors among the normal; for roughly twenty percent of the world's work lies within the scope of the retarded. In addition, the mentally retarded in the main will not do well on the assembly line. This again is contrary to popular opinion; but the truth of the matter is that the retarded do not do well under pressure. They work best in small groups where they have direct access to some supervisor who will make decisions for them.

Often it is asked why mental retardation occurs. As recently as thirty years ago it was thought heredity played the most important part in producing mental deficiency; and it is true that the offspring of a given set of parents tend to cluster in mentality around the mentality of the parents. But there are many other causes of mental retardation, which we now believe are much more important numerically in producing such a handicap. Among these, the most important are growth abnormalities, endocrine imbalance, birth injury, brain inflammation, concussion, and an RH blood dissimilarity.

In many ways, it is more important to know what damage has been done than why such damage arose; and again, in general, it can be said that what has occurred has been a damage to the cells of the brain. Free orange juice, slum clearance, love of parents, siblings, and community—these may in certain instances prevent mental deterioration. But when such deterioration has occurred, orange juice, slum clearance, or love, as far as we now know, cannot restore what already has been destroyed. With our present knowledge there is no cure for mental retardation. As Berry and Gordon have stated, it cannot be cured, it must be endured. And this goes for such old treatments as skull-splitting and such new treatments as the McKahn-Beck back re-vascularization operation and the lobotomies and topectomies. It goes for the work of Bernadine Schmidt and for other forms of psycho-therapy.

We do not know what the future will bring. Perhaps tomorrow will produce some cure for mental retardation. But as far as we know the mentally retarded always must be protected; and if they are to give back some portion of their keep to society, they must have special education as children.

Heretofore it has seemed necessary to mention some of the unpleasant aspects of mental retardation. It can be pointed out, however, that there are many hopeful things to be said about it. In the first place 80% of the lowest 3% of the population can be made vocationally self-supporting in private industry. 90% of the mentally retarded can be made socially acceptable.

This, however, can be done only by a different form of education. It cannot be done by a watered-down type of education. It cannot be done by leaving these children in the regular grades to pick up by osmosis in little bit less than just enough. It cannot be done by a remedial form of education where these children are put into special classes for a short time during the day in order that they may be returned to the regular track of curriculum. Mental retardation cannot be remedied. Neither can these children become self-supporting, acceptable, reasonably happy individuals by a happiness program within the special class. One institution for the retarded has over its doors "Happiness First, All Else Will Follow". This, however, is not true, though it is true that mentally retarded children, like all other children, must be released from emotional tension in order to do their best.

The mentally retarded must have a different developmental program. This program must be carefully thought out so that it is known at the time a child enters school what he will do during his entire school life. And this curriculum must contain the experience and answers that the child must make as long as he lives. In other words, we must think through what the child will have to do and then habituate him in the doing of these things. Moreover, in the working out of such a program there must be the most rigid of standards. The mentally retarded child at least cannot be permitted to perform in a shoddy way of industry will not pay for such shoddy production.

I overheard two men say recently: "There is no passing in the sky." The men were talking about their sons. The one man continued: "When your're piloting an aeroplane up in the sky, you either have to know how to do it or you don't. You can't get a passing mark." It often is said that this is cruel. Actually it is only a question of the "when of the cold shower." It is kinder to let the retarded know what society will demand of him while he is in the comparative security of the classroom than to let him find it out for himself when there is no one around to whom he can turn. We in New York have stated it this way. There are a new three R's in education, not reading, writing and 'rithmetic, but reality, relatedness, and responsibility.

Collectively parents already have done much. I honestly believe that the finest thing that has happened to the retarded in may years was the formation of the national parents' group here in St. Paul in September, 1950. For increasing public understanding, for acting as a political force, and for creating new ideas among the so-called professionals, none can act as effectively as can a national parents' group.

There is much that the several states can do for the mentally retarded. And one of the first things that must be done is to see that each state rises to the best in the nation. In other words, Minnesota for years has led the way in the committing of a mentally retarded individual, not to a given institution, but to a central office that may transfer the youngster to a training school or transfer him to a job, or return him to a hospital for special help, or in many other ways act as his true guardian in the finest sense of the word. Many states now have compulsory classes for the retarded in any community where there are ten or more such children. In Pennsylvania it is mandatory to have an assistant to the county commissioner of education charged with the testing of such children and the supervision of the special classes. New York has provided colonies or homes wherein these children can stay after they have been trained at institutions and are ready to work in private industry in a community. Connecticut has led the way in an effective program of vocational placement and follow-up for the retarded. And New Jersey has led the way in setting up a commission charged solely with studying the needs and most effective program for the retarded. Every state should follow these leads. In the main, it should be the aim of every state to see that these youngsters have first-class citizenship.

In a world seemingly gone mad, there is much to be said for working with the retarded. For here at least, we are certain that we are doing something infinitely worthwhile.

AN OVERVIEW OF A COMPREHENSIVE PROGRAM

Richard H. Hungerford

Group Length of time services are needed.	I - Those in need of a continuing protected environment (about 1/3% of total population)	II - Those in need of sheltered conditions in ordinary society (about 2/3% of the total population)
Continually	Stimulation of public understanding and sympathy. Prevention (wherever possible) Physical rehabilitation or amelioration (wherever necessary) . bio-chemical surgical psychiatric	Stimulation of public understanding and sympathy. Prevention (wherever possible) Physical rehabilitation or amelioration (wherever necessary) bio-chemical surgical psychiatric
First six years of life	Identification (soon after birth) Parent education (soon after birth of child) Placement in a protective commonwealth (soon after birth) - (continuing)	Identification (soon after birth) Parent education (soon after birth of child) Placement in a nursery class (about four)

FOR THE MENTALLY RETARDED

III - Those in need of limited supervision in ordinary society (about 2% of the total population)

IV - Those ordinarily in need only of special education (about 4% of the total population)

Stimulation of public understanding and sympathy.

Stimulation of public understanding and sympathy.

Prevention (wherever possible)

Prevention (wherever possible)

Physical rehabilitation or amelioration (wherever necessary)

Physical rehabilitation or amelioration (wherever necessary)

bio-chemical
surgical
psychiatric

bio-chemical
surgical
psychiatric

Identification (at latest
before exposed to formal
reading)

Parent education (as soon as
child's handicap is discovered)

Placement in a special day
class (before seven)

- a. an administration with
balanced responsibility
and authority
- b. specially trained per-
sonnel specially
compensated
- c. adequate and competent
social service
- d. a different developmental
curriculum school program
with social and vocation-
al objectives
- e. special occupational
high schools or units

Special recreational
facilities (continuing)

Special summer camps

Special vocational placement
services

Special social adjustment
services

- personal
- legal
- recreational

Identification (as soon as
impracticality of a regular
academic program becomes
apparent)

Parent education (as soon as
child's handicap is discovered)

Placement in a special day
class (by thirteen)

- a. an administration with
balanced responsibility
and authority
- b. specially trained per-
sonnel specially com-
pensated
- c. adequate and competent
social service
- d. a different developmental
school program with social
and vocational objectives

Adequate recreational
facilities (continuing)

Availability of vocational
placement services (in
existing local or state
agencies with expanded
facilities)

Availability of social adjust-
ment services (in existing
local or state agencies with
expanded facilities)

From six to seventeen

Placement in a training school
(before thirteen)

- a. an administration with
balanced responsibility
and authority
- b. specially trained per-
sonnel specially
compensated
- c. adequate and competent
social service
- d. a different developmental
school program with
social objectives
- e. special vocational train-
ing in a work camp or a
sheltered workshop

After seventeen

Special recreational
facilities within the
community

Sheltered workshops or work
colonies

Special social adjustment
services

- personal
- legal
- recreational