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EDITORIAL

It is said, again and again, and with much justification, that the large institution or hospital, de-humanizes the patient and that the institutional environment frustrates every honest endeavour to help the individual patient. Prolonged residence in the institution has been blamed for the impression that a patient leaves in the end less socially capable than when he came in. Many efforts are made to overcome the inherent disadvantages of living in a large well-organised institution which does the thinking and acting for the patient rather than encouraging him to do it for himself. However, little thought has been devoted to the proposition as to how a new institution, a new hospital could be planned and organised in every detail to **support** therapeutic endeavour rather than simply to house it.

Probably a good deal of our trouble is due to the fact that we can only think in terms of improving and 'upgrading', a concept handed on because many people still believe in the organisational necessity for a traditional type of institution. Others think of abolishing the institution altogether and are prepared to go without the advantages of such a closely knit organisation because it never functions to perfection. It is argued that the monotony and the regulated life of the institution suffocates the little there is one can develop and that only life in the open community can give the vital stimulating experience.

We believe much of this criticism is justified—the institutional minds of the planners, administrators and professional staff have entangled themselves in the fallacies of adhering to conventional meanings and are spellbound by experience and tradition. In consequence 'improving' the hospital means in the end only the most technically perfect interpretation of the most old fashioned and obsolete concepts.

Dr. Dybwad in his address at Montpellier ⁽¹⁾ pointed out that "buildings have been designed, even in the most recent past, to facilitate with maximum efficiency the various care, treatment and training and rehabilitation procedures. Based on

detailed studies of staff time and walking distance required to perform certain functions, and on such factors as maximum visibility at all times of the group under care, highly sophisticated design patterns have been developed that achieve all this but alas! at the expense of considerations for the individual resident, and at the expense of the goal of providing an environment as nearly similar to normal situations as possible. Thus one can see an oddly shaped building for severely and profoundly retarded where the toilets form the focal point in the centre of the building. This provides undoubtedly easy accessibility but also a strange and limiting setting for daily living”.

The proverbial uniformity of the institution whether reflected in the nurses' neat, hygienic but ever so regular uniforms or in the uniform layout of the wards throughout the institution, how much of this is really needed? Is it necessary, indeed desirable, to have the same fittings, the same furniture, the same type of dresses, the same time table, the same leisure occupations throughout the place? Of course, this institutional attitude can be rationalised by arguing that the subnormal will be confused and puzzled unless everything is so familiar as not to present any problems. This argument indicates a curious inconsistency of purpose. At school we try to help the mentally handicapped child to stride forward, to find out for himself, to learn about all sorts of things, and we go to a lot of trouble to invent and make visual and mechanical teaching devices to further these aims. Leggo and Meccano sets are required, domestic equipment of different types is introduced, shopping expeditions and outings become regular features to make the child accustomed to a mass of very ambiguous, confusing and contradictory experiences which we help him to sort out. Yet, he is deprived of all this fun and excitement once he returns to the institutional ward where people have gone to great lengths to make sure that every door, every locker, every bed and every table look the same . . . with the consequence that we deprive him of a chance to progress in a natural and easy way.

This is quite unnecessary institutionalism but is surely not inherent in an institutional set-up. If every day looks the same, if the same deadly dull routine were to dominate our and our children's lives, what would our reaction be? Cabbage on Tuesday, pictures on Wednesday, dance on Thursday, bathing on Friday . . . how stimulating, how exciting . . . so much fun!

The institutional world will in one way or the other remain with us for a long time to come. If the starchiness, the uniformity, the regularity, the monotony and the lack of free enterprise are taken out of it by allowing individual institution units to function as autonomous homes where fun, change, unexpectedness, individuality in living are introduced as natural components of homelife, the worst and depressing aspects of institutional life may well disappear and with it . . . the institutionalized patient.

¹ D. G. Dybwad, Changing Patterns of Residential Care for the Mentally Retarded. *Proceedings 1st Congr. Intern. Assoc. Scientific Study Ment. Deficiency*, St. Lawrence's Hospital, Caterham, Surrey, 1968. pp. 575-580.