

CHAPTER FIVE: A HISTORICAL PERSPECTIVE

Having attempted a review of the global situation for disabled people, I will now look at the historical perspective.

There are three principal reasons for this:

- to better understand the situation described in the previous chapters;
- to see what lessons can be drawn from the past; to identify and apply positive experience while avoiding duplication of mistakes;
- to review the major concepts related to disabled people and to choose the most advanced and most humanitarian principles to guide the implementation of rehabilitation in the developing countries.

Over the centuries, the prejudiced beliefs, attitudes and behaviour of non-disabled people have largely determined the quality of life and the fate of disabled people, and they still do.

Reactions to the presence of human beings with disabilities may be grouped under five main headings:

1. **elimination** - getting rid of them;
2. **the poorhouse** - removing them from the view of the non-disabled;
3. **institutional care** - providing care for them on a segregated basis;
4. **integration** - encouraging a process that would lead to the integration of disabled people in their families and communities, as well as in the general systems of society;
5. **self-actualisation and empowerment** creating the conditions, so persons with disabilities can develop their full potential.

Historically, the general trend in the development of concepts has been away from elimination and toward self-actualisation. But concepts are one thing and reality is another. To this day, all five of these reactions are still in evidence. So let us look at the elements of each of them.

1. ELIMINATION

As a reaction to disability, elimination characterised mainly by the premature death of a disabled person - a fate shared by millions of them. For the purposes of this publication, the term "premature death" indicates that the death was *not* directly related to disability or to its causes. This would, for example, be true in the case of an infant dying from a severe, disabling malformation of the heart. Premature death in our context has brought about by other human beings, either directly or indirectly.

The most infamous example of "premature death" is the systematic killing of mentally disabled people during World War II in Nazi Germany. At the Nuremberg Trial of war criminals, it was estimated that 300,000 people¹ with such disabilities had fallen victim to Hitler's euthanasia programme².

Even in our days, the survival of disabled people is jeopardised by widespread prejudice among able-bodied people. The behaviour borne out of such prejudice has led, and still leads, to premature death caused by negligence or by intent, as described in the following document on the situation in a developing country:

"Before the advent of hospitals, child welfare and maternity clinics, women gave birth in their ancestral homes. Before a newborn baby was officially announced, he was thoroughly examined for any visible defects of the body. A baby with any physical defect was promptly eliminated. The family was informed that the baby was still-born. Congenital deformities were, therefore, not much of a social problem".³

Negligence of females with a disability is in some countries more pronounced than that of males

(Chapter Two). Misinterpretation of Darwinian theory - and in particular of the phrase "survival of the fittest" - has contributed to the belief that it is somehow in the best interests of societies to let the most vulnerable go under.⁴

In our days, elimination is practiced in many industrialized countries, where it is culturally and legally acceptable to diagnose the presence of a defective foetus by amniocentesis or similar techniques and to grant permission for an abortion should the diagnosis be positive. In several countries, murder of an infant or child with a congenital defect will sometimes lead to nothing more than a suspended sentence and the public at large appears to be strongly in favour of such judgments. Recently, it was proposed (in a European country) to legalise infanticide committed during the first three days after the birth of a severely handicapped baby, a practice said to exist already clandestinely, on a limited scale⁵.

On the other hand, arguing in favour of the view that "parents of severely disabled newborn infants should be able to decide, together with their physician, whether their infant should live or die," sometimes meets with strong opposition⁶.

2. *THE POORHOUSE*

The "poorhouse approach" is an attempt to help the "impotent," "lame" or "feeble-minded,"⁷ as well as unemployed and aged individuals, orphans and other groups of destitutes without any source of income.

The first poorhouses in Europe were set up by municipal action in the early 16th century, at a time when the medieval economic system was on the decline and the needs of the poor could not be met by charitable, religious organisations.⁸ The motive behind the creation of poorhouses does not appear to have been mainly charitable. Rather, it was the fear that vagrants might spread disaffection and that some might be recruited as mercenaries for rebel armies. To save costs, the local authorities in many communities gave the aged and those unable to work a licence to beg.

Not until very recently did the poorhouse disappear as a component of European and North American municipal structures, which raised "poverty taxes" to cover costs for the subsistence of the poor and the undesirable. These taxes supported many different groups, such as people with disabilities, with unusual behaviour or appearance, chronic alcoholics, criminals released from prison, the severely ill, members of certain ostracised ethnic groups, people thought to be carriers of communicable diseases (including epilepsy and organic brain disorders), orphans, or others who simply happened to be jobless.

There are many interesting features to the poorhouse approach. The obligation "to put the poor to work" was instituted in England in 1601. This was thought to contribute to rehabilitation of the poor. Working conditions in the poorhouse were designed to act as deterrents to taking advantage of the system. Paupers had to wear special uniforms or garments. In some countries they were made to wear a large red or blue, plainly visible letter "P". They were denied the right to vote and subject to harsh discipline.

By the middle of the 19th century, the repressive "poorhouse" system started crumbling, helped by such factors as the development of democracy, humanitarianism, social security and more scientific approaches to dealing with poverty.⁹

But many of the attitudes associated with the poorhouse approach have persevered into our days, even among some highly educated people. Poverty is not infrequently thought to be a sign of God's disapproval. Many able-bodied people still prefer to make voluntary contributions or pay taxes in order to have poor disabled people removed from their sight and cared for by custodial staff.

Today, the poorhouse as an approach is rare in developing countries, high costs being one of the main reasons, so it seems. Communities generally accept to have a certain number of marginal people living amidst them - mentally ill persons, beggars, jobless and destitute people, and others. Also, there often exists a limited welfare system: families, friends or neighbours taking care of their needs in terms of food,

clothing and shelter.

Mental hospitals in these countries sometimes function as a type of poorhouse, in particular for those affected by mental retardation or disease.

3. INSTITUTIONAL CARE

The first large-scale institution for disabled people in Europe seems to have been the "Hotel des Invalides".¹⁰ Built in Paris between 1670-77 by King Louis XIV, it was designed specifically for disabled and aged soldiers. Eventually it housed 7,000 such veterans. This institution still exists today, though on a much smaller scale.

Institutions have also existed for centuries in several developing countries. In Sri Lanka, for example, King Buddhadasa built a very large institution as early as in the fourth century¹¹.

Later on, about 200 years ago, institutional care for "civilians" began to emerge as a "specialisation of the poorhouse." The "inmates" were divided into distinct groups and sent to separate boarding institutions, among them institutions for various groups of disabled people. Detention and charity were combined with rehabilitation, special education, therapy, vocational training and sometimes with a job in a segregated, "sheltered" surrounding.

New technology too began to emerge, such as characters in relief for blind people, a system used by l'abbé Valentin Haüy in 1784. This inspired the creation of the first specialised school for blind children in France. Louis Braille in 1824 invented the system, now used by millions of blind people.

As countries became more affluent they tended to improve the image of such specialised poor-houses by ensuring a higher density of personnel, increased freedom to visit the neighbourhood, and less conspicuous signs of charity. Detention was enforced by creating psychological dependency rather than by locking doors.

In many places, the segregated institutions improved the technical rehabilitation programme. In "centres of excellence," disabled people were well "looked after." They developed many of their abilities and skills to become more mobile, more advanced in communication, better educated, more productive at work. More was done to assist them in finding their way back to their families or in trying to lead an independent life.

Yet, up to our own days, institutions have continued to be the subject of heavy and justified criticism. A few years ago, the United States Supreme Court noted the undisputed facts about a large, well-known institution for mentally retarded people:

*"Conditions ... are not only dangerous, with the residents often physically abused or drugged by staff members, but inadequate for the 'habilitation' of the retarded. Indeed the court found that the physical, intellectual and emotional skills of some residents have deteriorated."*¹²

Institutions are still the dominant type of facility for rehabilitation in the developing countries. The most common clientele are children receiving schooling and functional training. In addition, there are a number of facilities that provide orthopaedic appliances and gait training. Others aim at preparing people for employment or offer them sheltered work.

The establishment of day-care facilities for disabled people began mainly after World War II. Such facilities provide a better solution than residential, totally segregated institutions. Day-care can do much to support families, which for several reasons are unable to take full care of their own disabled members. This step was followed by attempts at integration.

4. INTEGRATION

The conceptual evolution towards social integration and de-institutionalisation is the outcome of a gradual change in a number of factors, the most important of which are:

- new medical inventions,
- the lack of an adequate number of professionals or of effective remedies,
- economic necessity,
- the reactions of millions against authoritarianism, colonialism and paternalistic attitudes, and finally
- the growing influence of disabled people and parent groups.

At the end of World War Two, millions of disabled veterans returned home, stayed there and were integrated in normal community and family

life. It is true, a number of veterans' hospitals and other facilities were set up to help with medical care and rehabilitation, but the idea of keeping all disabled veterans in institutional settings, i.e. creating a sort of large-scale 'Hôtel des Invalides', did not seem practical. Thus social integration became the solution, but out of economic necessity rather than choice. It did not cause any major problems, nor did it lead to lower-quality results.

The next decade, with the economic situation improving in a number of Western countries, marked the onset of a period of escalated construction of new institutions for disabled people. This development was paralleled by a tendency among a growing number of parents to prefer to keep their disabled children at home. Increasing prosperity, better housing conditions and higher levels of education made this possible. Day-care facilities and mobile specialists later helped many such families. The 1950s saw the beginning of a great revolution in psychiatry. This was precipitated, among other things, by the invention of new psychotropic drugs which simplified the care of patients with chronic psychoses. In fact, they recovered to such an extent that, given a community psychiatric service as a supporting structure, many could be sent home or be admitted to halfway houses. In all industrialised countries, the majority of closed wards for the severely mentally ill were opened up. Several hundreds of thousands of patients were discharged to live outside the institution, either temporarily or permanently.

Economic constraints were a major contributor to this change. In the decades before 1960, tuberculosis accounted for the majority of deaths in institutions for disabled people and in hospitals for the chronically ill. With the invention of new drugs and the availability of BCG-vaccination, the death toll from tuberculosis declined considerably. With the disabled people living longer, specialised institutions and hospitals became overcrowded. The lack of funds did not permit the further expansion of existing facilities.

So, in order to make room for new patients, the least disabled had to be discharged, sent home. Their needs for care had to be met by day-care centres rather than by closed wards.

The "space problem" was an interesting phenomenon. Initially, doctors were put on the defensive, apologising to patients and their families, and blaming the politicians for not raising taxes to pay for the institutions "needed". Later on, attitudes changed. The merits of social integration were discovered, and going home became part of an active and planned effort.

Another factor contributing to this change was the emergence of self-care programmes. These were set up either to cope with the shortage of professionals or because the therapy provided by the professionals failed to produce the desired results. Alcoholics Anonymous, which was started because most professional programmes had turned out a failure¹³, is an excellent case in point. Alcoholics felt that they could do better on their own, and they started group therapy sessions on a regular basis. Today they have local organisations in almost every country.

Another movement that made its appearance in the period between the fifties and the seventies was the so-called "therapeutic community," encouraging mentally ill patients to become more independent, or totally independent, of professional care-providers¹⁴.

These two examples of rebellion are not indicative of the search for true social integration. Rather than breaking new ground, they continued to follow the old pattern of bringing together segregated groups of

disabled people. However, their challenging of the authoritarianism exercised by professionals has been an important element in the development of the self-care concept.

De-institutionalisation was furthered by other factors. One was the rapid increase in the number of elderly disabled persons in industrialised countries, which strained all care facilities to the utmost. The professionals became over-extended and had to find solutions to cope with their daily workload. Physiotherapy departments started encouraging self-treatment of chronic conditions, using simple training packages for in- and out-patients suffering from stroke, arthritis, back disorders and other complaints. Parents of children with cerebral palsy were visited at home at about monthly intervals and given instructions and demonstrations on how to proceed with the training themselves. Many rehabilitation professionals changed their roles from that of therapy providers to teachers of self-therapy.

The authorities, recognising the benefits of the new trends, began to promote these efforts by providing economic and organisational support.

When scientists began reviewing the results of such "home rehabilitation/self-care," they found them to be equivalent or even superior, in some respects, to the results obtained by institution-based rehabilitation. It was then recognised that the frequency of emotional and behavioural disturbances not primarily caused by the particular disability was higher in disabled children treated in residential institutions than in those trained at home. These disturbances were interpreted as side effects of the segregation typical of long-term institutional care. Many of the problems that disabled adults encountered in their contacts with non-disabled people, for example, in finding and retaining a job, could be attributed to their earlier segregation. Children receiving long-term care in boarding institutions often develop a special language (argot), which further impairs their ability to communicate with outsiders. Family integration and integration with a non-disabled peer group have been shown to diminish or eliminate such undesirable side effects.

Integration and home self-treatment (or treatment by a family member) of disabled people, under the supervision of professionals, is now an accepted method and has proved to be an effective and preferred approach.

With family integration as the starting point, many countries have embarked on efforts to further social integration, including integrated housing, schooling, vocational training and jobs, sports and recreational facilities, and so forth. Large-scale programmes were introduced to eliminate physical barriers in the environment - such as providing accessible public buildings, transportation and housing for people with mobility problems. All-round social integration has yet to be achieved. And prejudice is the main obstacle on the road to this goal.

In the most developed countries, long-term institutionalisation of disabled people is now considered a second-choice solution, to be applied only to those for whom no other approach is possible. Social integration is, however, achieved only in part. The approach faces many an obstacle, including the predominantly negative attitude adopted now as before by non-disabled persons, and by a number of professionals.

Another sizeable hindrance to implementing integration is the fact that some governments have contented themselves with closing down institutions, especially those for mentally-ill persons, without providing the necessary resources for community level care. Given the general downward trend in social welfare allowances, this has given rise to an alarming phenomenon - the appearance of large groups of "homeless people". The majority of them belong to the groups of the mentally ill, drug addicts and alcoholics. There is no doubt that the change from institutional care to community care and integration cannot be brought about without real community involvement and adequate networks of local care providers. This staff must not only be easily available but must, moreover, make frequent home visits to provide all necessary follow-up action. Furthermore, the community should make adequate provision for all daily needs such as rent, food and clothing, and set up at least a simple programme of daily activities.

Finally, we should acknowledge the very active role played by the "consumers", in particular in the industrialised world. Organisations of disabled people and organisations of parents have firmly established themselves in the past thirty years. They are increasingly consulted by governments and local authorities in matters of policies and programmes targeted at them. Their effectiveness in lobbying for human rights and equal opportunities is growing, leading sometimes to successful "rebellion" against inadequate programmes, paternalism and prejudice.

In many developing countries, the social integration approach has been there from the very beginning. As specialised facilities are scarce, most disabled people stay with their families and in their communities. For most of them life is not easy, though some of them do receive "spontaneous" rehabilitation from the family. It would appear that more disabled people have received effective rehabilitation through their families than through institutions, and that they have remained socially integrated as a result.

5. SELF-ACTUALISATION AND EMPOWERMENT

Self-actualisation implies that each disabled person should be able to fulfil his or her need for taking an active part in society and for living a life in dignity, independence and with self-esteem. This is the ultimate goal that rehabilitation aspires to - a goal not sufficiently acknowledged at the present time.

For a better understanding of the term "self-actualisation", it may be useful to review the basic concepts of human need, as described by Maslow¹⁵. In his "Theory of motivation" he describes five levels of human needs (material and non-material).

The the needs are presented in descending order of their importance:

- (1) Physiological needs are the essentials needed for survival, such as food, water, air, sleep.
- (2) Safety/security needs are those of security and protection against danger.
- (3) Social needs are those of belonging, affection and love.
- (4) Esteem needs are those of self-esteem (self- respect) and esteem by others (recognition).
- (5) Self-actualisation needs are those of self-fulfilment, to realise one's own full potential.

Most inquiries into disabled people's needs in the past have been very limited. The full scope of needs of people with disabilities has to a large extent been neglected.

It has been more or less presumed that once basic material needs are satisfied, conventional rehabilitation services and opportunities will be provided, and that, with this, the disabled person has "reached the highest possible level of ability" – all needs have been met. This view is too superficial to be acceptable. Esteem needs and self-actualization too have to be satisfied, and a more dynamic, holistic approach is necessary.

Let us apply Maslow's theory to sum up the situation of disabled people.

The actual survival of disabled individuals was and still is threatened in many ways. The poorhouse and, later on, institutional care, were approaches designed to protect the survival of disabled people and to provide the physiological needs for water, food, shelter, clothing and safety. This is as far as we have reached today for most disabled people in the industrialised countries - not so in the developing ones.

The feeling of belonging, of receiving attention and love, comes more easily to disabled people who live in the midst of their families and friends. The integrated approach offers ways of better satisfying these needs. Nevertheless, most organisations working for disabled people in the developing countries have concentrated on the residential institutions.

Esteem and self-actualisation needs can only be fulfilled if disabled people live in the community, share the same rights and play a proper, meaning-ful role in their respective societies.

The subject of empowerment is another important goal: to enable disabled persons to exercise their political rights. The subject is dealt with in more detail in Chapter 13.

In the industrialised countries, the social integration approach is slowly replacing institutional care.

Nobody disputes the fact that for some disabled people no solution other than institutional care can be found. All their relatives may abandon disabled children or adults. Their disability may be so serious that round-the-clock care is needed. The care may prove too costly or involve technical equipment that is difficult to handle at home. Behavioural disturbances may become so severe that they are too much of a burden for a family to cope with. But, in reality, with early intervention programmes, such disturbances are rare. In several countries, it has been possible to reduce institutional care to a minimum.¹⁶

So the questions arise: Is there a way to avoid repeating the mistake of having the institutional system installed as the only model for services in the developing countries? Is there a way whereby priority can be given to a system building on social integration?

6. *THE RIGHT TO PUBLIC SERVICES*

The first actions in Europe to assist disabled people - during the medieval period - were set up by religious organisations. In the 16th and 17th centuries - when this system was breaking down - it was replaced by the poorhouses installed by local authorities.

Later on, a number of private initiatives emerged, for example the development of special education for blind and deaf children, "homes for the crippled" and so forth.

In the 20th century, in the industrialised countries, numerous services were created in the private sector, financed by voluntary organisations - reflecting the growing influence of associations of parents or disabled people and the availability of donated money. This is the pattern most commonly copied in the developing countries.

But in the last few decades, this tendency has been the subject of severe criticism in the industrialised countries. The question is: Why should disabled people be dependent on charity? Why can they not have public services like everybody else? Why are not all schools for disabled children managed by the education department or by local authorities, just as "normal schools" are? Disabled people argue that they are treated as beggars and become dependent on charity.

So, in the more advanced societies, the services of private charitable organisations, along with economic contributions to disabled individuals, are in the process of being taken over by the public sector. Social security and other government systems increasingly take care of the economic side, including subventions and pensions.

In the developing countries, it is common to see disabled people begging. In many ways the culture and social stratification of many societies legitimise the dependency on begging and charitable action. But, in the long run this will diminish and disappear. Disabled people in the developing countries will - like their brothers and sisters in the industrialised world - demand that the authorities step in and replace charitable action by public services and social security.

7. *LESSONS TO BE LEARNED FROM THE HISTORICAL PERSPECTIVE*

The positive experiences of the past indicate that a rehabilitation programme in developing countries should incorporate a number of priorities:

- functional training approaches based on the modern technologies of self-care and home-care. To

succeed, one must obviously try to demystify the technology, so as to make it easy to understand and to apply. Families and communities need to be mobilised to provide the care and rehabilitation needed;

- a system of schooling that is accessible to the disabled children where they live, and emphasising inclusive education;
- total social and economical integration coupled with a programme of community preparation aimed at ensuring equal opportunities, better recognition, more positive attitudes and the disappearance of discriminatory behaviour towards disabled people;
- less paternalistic and authoritarian attitudes among professionals involved in the supervision and in referral care systems;
- interventions in the environment to reduce or to eliminate physical, psychological, cultural, social, and economic barriers;
- increased respect for the human rights of disabled people;
- efforts that promote self-actualisation and empowerment, defining new roles for disabled people to look after their own interests and to influence society as a whole through their own organisations or interest groups. This would liberate them from the influence of power structures not of their own making and allowing them a life in dignity, on an equal basis with all other members of the common human society;
- far greater emphasis on adequate organisation of service delivery - leaving behind a system characterised by costly fragmentation, under-performance, and lack of co-ordination. A well-functioning organisation for total coverage cannot be achieved without government involvement.

Concepts described in this chapter are poorly understood and even less applied, in real life. Few people who have heard of the principles of social integration and self-actualisation have tried to implement them.

Innovative ideas call for innovative solutions; it is not adequate to go on with the conventional system, thinking that next time around perhaps it will not fail. In order to be innovative we need to experiment with new strategies. We need to find better solutions, which integrate the most advanced and humanitarian principles into the design of the rehabilitation system.

COMMENTS AND REFERENCES

¹Wolfersberger, Mental Retardation: 19:1, February 1981.

²At the Nuremberg Trial, a Nazi official made the following statement:
"Hitler's ultimate reason for the establishment of the euthanasia programme in Germany was to eliminate those people confined to insane asylums and similar institutions who could no longer be of any use to the Reich. They were considered as useless objects and Hitler felt that, by exterminating these so-called eaters, it would be possible to relieve more doctors, male and female, nurses and other personnel, hospital beds and other facilities, for the Armed Forces."

³J. Amoako in Expert Group Meeting on Social Services, United Nations, Geneva, Switzerland, 1976.

M. Yaqoub et al. Severe mental retardation in to 24-month-old children in Lahore, Pakistan: a prospective cohort study. *Acta Paediatr.* 84, 267, 1995. The authors found a cumulative incidence of severe mental retardation of 11 per 1,000 live births during the age of 2 to 24 months. Down's syndrome was the cause in 36% and consanguinity was present in all but one person who had a non-chromosomal caused severe mental retardation. The mortality of these children during the study period was 36%, all caused by respiratory infection. These results clearly reflect a process of elimination.

⁴H. Spencer, "The Man Versus the State", London, United Kingdom, 1884.

⁵Le Monde: 17 November, p.22, 1987.

⁶P. Singer: On Being Silenced in Germany, The New York Review of Books, Vol. 38, Nr. 14, August 15, 1991.

⁷These are terms used in the 17th century to characterise disabled people.

⁸An early description appears in Juan Luis Vives: *De subventionem pauperum sive de humanis necessitatibus*, 1526. A review of the history of the poorhouse appears in D.L. Disert: *Entre la peur et la pitié*. *Int.J.Rehab.Research*, 10(3), p. 253, 1987. The oldest, still existing "poor house" is the Portuguese Santa Casa da Misericordia, founded in 1498. Today its main activities concern homes for elderly.

⁹A review appears in *Encyclopaedia Britannica*: "Poor Law", 1970.

¹⁰Source: *Encyclopaedia Britannica*, 1970.

¹¹King Buddhadasa "built island refuges for the physically disabled and blind." His son Uptissa "erected great nursing shelters and alms-halls for cripples, women in travail, for the blind and the sick."

Source: T. Jönsson, *Children with Special Needs in Sri Lanka*, SIDA, Colombo, Sri Lanka, 1984.

¹²S.S. Herr, *Columbia Human Rights Law Review*, 12:1, 1980.

Another well-documented tragedy in the United States concerned a large institution for disabled children and adults in Willowbrook on Staten Island, N.Y. In 1972, a television crew entered a ward where there were "60 emaciated children, many naked, some in straitjackets, a place with feces smeared on the walls, and a single attendant. It was the impetus for a Federal Court suit... The federal judge would not settle for a better Willowbrook. He wanted the 5,400 residents moved out." *New York Times*, 18 December 1991. See also D. and S. Rothman: *The Willowbrook wards*. Harper & Row, New York, USA, 1984.

Similar living conditions still exist in a large number of institutions for disabled people all over the world. The conditions under which 40,000 disabled children used to live in state-run institutions in Romania were described in the press as one of the worst horror stories of modern times.

¹³A.A. was started in 1935. Its most significant growth occurred in the last twenty years. In 1982, the organisation reported an active membership of one million, forming 48,000 groups in 110 countries. (From "Alcoholics as a Resource for the Medical Profession," London, United Kingdom, 1982).

¹⁴Maxwell Jones, *Social Psychiatry in Practice. The ideas of the therapeutic community*, London, United Kingdom, 1968.

¹⁵A.H. Maslow, *Motivation and Personality*, Harper Brothers, New York, USA, 1970. Maslow's model has met with criticism, as it appears over-simplistic. The hierarchy of needs proposed by him does not apply to all. To give an example: some people are prepared to sacrifice their safety and their lives to gain the esteem of others, or for a specific cause.

¹⁶In Sweden there were in 1970 about 2,500 children placed in residential institutional care. Out of these, about 500 were under the age of seven. In 1990, 22 children under 7 remained in institutions, all of them severely disabled. By 2000 all persons with disabilities will have moved out of residential institutions to individual homes, with services provided when needed.

The state of Michigan, USA, diminished the number of places in institutions from 12,000 to 700 people in 20 years. In January 1991, New Hampshire closed its last institution (*N.Y. Times*, 18 December 1991).