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The Sunland Training Centers: Florida's Institutes for Children with Intellectual Disabilities

Kim Curry, PhD, ARNP

ABSTRACT

Developmental disabilities affect about one out of every six children in the United States. These conditions create significant financial and social costs to families and society. Specifically, questions have long arisen as to how best to manage the needs of persons with intellectual disabilities. Historically, the nomenclature used to address intellectual disabilities has evolved as has the philosophy of venues to provide optimal care and the development of specific skills for conducting this care. Considerable dissension still exists about the type and nature of institutional care for even the most profoundly disabled individuals. This paper reviews relevant history, including laws, regulatory measures, and landmark judicial decisions with a special focus on Florida.

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BACKGROUND

Societies face the issue of how best to manage the needs of those with intellectual disabilities. Prior to the 19th century, children born with such disabilities were typically cared for in the home. In the first half of the 19th century, experimental schools became popular in Europe. These schools focused on the education of children commonly referred to as "idiots." School founders were optimistic about the potential for affected children to be taught and returned home to live with their families (Tyor & Bell, 1984). The schools were designed for short-term residential education, and always with the long-term plan of returning the children permanently to their families.

Early experimental schools in the United States were also designed for education and development. Until the 1850s, many children attended these schools at the usual school age, and returned home at regular intervals. Six states established schools for the retarded prior to the American civil war. Most of these were designed after a school founded by Edoard Seguin in Paris, and similar schools in Europe. Seguin's school was visited and studied by several leaders of the early schools in the United States (Trent, 1994).

In the mid-19th century, the rather genteel term "feeble-minded" began to emerge as a label for these individuals. At the same time, societal views of those with feeble-mindedness began to shift. Experts were beginning to be able to explore some medical reasons for cognitive problems, and society began to view

factors such as alcoholism, the surge in immigrants, and poor parenting as contributing problems. This, in turn, led to parental guilt and regret in families with affected children. The view of these children began to be that of a potential threat to society as studies were made of links between mental deficiencies and delinquency. Feeble-minded individuals were viewed as a drain on the resources of the family and the state, and were felt to be especially susceptible to corruption, including various types of criminal and sexual behavior, the latter leading to future generations of dependents and delinquents (Rafter, 2004).

In 1916, Henry Goddard, the Director of the Research Laboratory of the Training School for Feeble-Minded Girls and Boys at Vineland, New Jersey, published an influential book making an argument for the hereditary basis for feeble-mindedness (Goddard, 1916). Goddard was a proponent of the eugenics movement that had been growing in popularity after the publications of Darwin's *On the Origin of Species by Means of Natural Selection, or the Preservation of Favored Races in the Struggle for Life* in 1859. The eugenics movement became popular. Goddard was an advocate of forced sterilization to prevent breeding of feeble-minded individuals. As an alternative to this socially offensive option, however, he supported keeping deficient individuals in institutions (Plucker, 2013).

Medical knowledge of the etiologies of various types of intellectual disability developed slowly during

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the first half of the 20th century. The term “feeble-minded” continued to be used in the professional literature at the midpoint of the century, and medical experts treated conditions such as Mongolism, now called Down Syndrome, with such therapies as thyroid hormone supplementation. However, the children also received special education, and emotional care and support. Some experts by this time recommended that families consider admitting the affected child to a training school to avoid undue stress on the normal members of the family (Kugelmass, 1954).

AN INSTITUTE FOR THE FEEBLE-MINDED COMES TO FLORIDA

In 1918, Governor Sidney Catts requested a social welfare plan be developed for Florida. The report was completed by the Russell Sage Foundation, a national social research foundation that had been formed in 1907. The directors of the Sage Foundation made a recommendation that Florida make provisions for the institutional care of feeble-minded individuals. Such individuals were considered to be the most important social problem of the time in Florida (Noll, 1990). In 1919, the Florida Legislature authorized the creation of a state institution “for the care of the epileptic and feeble-minded, where they can be segregated and more economically cared for than through the numerous charitable organizations now burdened with these unfortunates” (Lundgren, 1961). Thus, a place was created to house sufferers of two conditions thought at that time to be closely related.

At the time that Florida created its colony, there were already 206 institutions involved in caring for feeble-minded persons elsewhere in the United States (Hodges, 1920). The Florida Farm Colony for the Epileptic and Feeble-minded opened on the outskirts of Gainesville, and began admitting patients in 1921. The land was a tract of 3000 acres donated by Alachua County as a means to provide jobs to county residents. James Hodges, the first superintendent of the colony, noted that “the land is not of extra good quality, being cut-over pine land, but is sufficiently productive to yield a large amount of food for the Colony, when put in a proper state of cultivation” (Hodges, 1920). The plan was for residents to be trained to work the farm; thus, the colony would be self-sustaining, minimizing mingling with those outside.

The Florida Farm Colony had a capacity of 550 patients by 1939, when the name of the institute was slightly altered to reflect new nomenclature (Dell, 1939). It became The Florida Farm Colony for Epileptic and Mentally Deficient Children. Thus established, it remained the only public facility for mentally retarded children in Florida for over 30 years.

Reflecting the entrenched racial segregation in the state at the time, only Caucasian children were eligible for admission until 1953, when the first Negro unit opened at the Colony (Lundgren, 1965).

A SHIFT OF OPINIONS

By 1950, scientific knowledge of the causes of mental retardation had incorporated intelligence testing and other observations of variations in physical and neurologic characteristics among children with different syndromes. Classification systems were developed that were based on these measures of “amentia” (Table 1). Kugelmass (1954) noted that “the undeniable limitations of the severely retarded child, for example, encourage custodial care, even though only 5% of the ament population is institutionalized,” but also that “the indiscriminate dependence on intelligence tests often blinds us to more important aspects of the ament’s behavior.” Medical practitioners were evolving in their desire, if not their ability, to individualize care.

At the same time, growing public awareness that governmental institutions were not meeting the needs of children led to the creation of the National Association for Retarded Children (NARC). NARC was formed with the cooperation of several state-based parents groups of affected children. By 1957, members of NARC had developed a 10-point bill of rights for retarded children. This plan addressed the needs of children who were often hidden or exiled, and also addressed children cared for at home and those in institutions (Capa & Pines, 1957). The bill of rights foreshadowed numerous federal disabled rights acts that would come decades later.

Despite the beginnings of a national shift in opinions about the appropriateness of institutionalization, the demand for beds in Florida’s institutes continued to grow, reflecting a more conservative approach to implementing change that was characteristic of many southern states. In 1957, the Florida Legislature created a new state agency, the Division of Child Training Schools. The first director, Arthur Dozier, was placed in charge of the “Sunland Training Center” at Gainesville, another training center yet to be built, and three other state schools serving other purposes (Underhill, 1957). All of the institutes were renamed by legislative act. Thus, the Sunland Training Centers came into existence.

The demand for placement of children in the existing training center was high. By 1959, the Gainesville Sunland had 1400 children, with a waiting list of 800 more, and a typical wait time of 18 months for admission. Therefore, a Sunland Training Center

was being planned for Fort Myers, in the southern part of the state (Florida State Board of Health, 1959).

STATE GROWTH AND NATIONAL CONTROVERSY

During the early 1960s, the term "mental retardation" found acceptance over more archaic term (Edgerton, 1967). Nationally, many residential institutions for the mentally retarded had swollen to enormous sizes. In 1960, the average patient capacity of a public institution for the mentally retarded was 1500 residents. By 1967, the number of individuals residing in institutions nationwide was over 194,000 (Willer & Intagliata, 1984).

Several changes were occurring in the United States that would permanently change the approach to the care of retarded citizens. After World War II and the Korean War, thousands of soldiers returned home with disabling mental or physical injuries, and the plight of these veterans began to create a heightened sensitivity toward the disabled. There was also a growing awareness that institutional placement of young children could be detrimental to their social, emotional, and cognitive development, due to the barren and non-stimulating environment found in institutions (Baroff & Olley, 1958).

In October of 1961, President John F. Kennedy appointed the President's Panel on Mental Retardation (White House, 1961). In 1962, the panel presented recommendations including the creation of a continuum of care and access to public education for mentally retarded children, among other items. On October 24, 1963, the president signed into law the National Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act in response to the recommendations. In addition, the federal Medicare and Medicaid programs were implemented in 1965 during the Lyndon B. Johnson Administration, further expanding the role of the federal government in medical care and providing funding for services to thousands of poor, elderly, and disabled individuals who had previously been uninsured.

In 1960, the second Sunland Training Center opened in Fort Myers, thereby giving Florida institutes at both the north and south ends of the state (Nourse, 2010). Despite the growing awareness of and attitudes toward the shortcomings of large institutional settings, the state Division of Retardation was primed for a rapid expansion of facilities for the mentally retarded.

By the early 1960s three of the State's four tuberculosis hospitals closed due to the advent of effective antibiotic therapy. To meet the evolving need for mental retardation facilities, a decision was made to

convert the tuberculosis hospital in Orlando to a Sunland Training Center. The children placed at the Orlando Sunland typically had a combination of mental and physical disabilities and were not ambulatory. The Orlando location continued to receive the most severely disabled and medically dependent children (Kelly, 1975).

Three years later, a fourth Sunland opened in Marianna to serve patients in the panhandle area. This center was built far outside of the town, on an abandoned air base. The center opened with a patient capacity of 288. By 1969, it had already expanded to a capacity of 1000 residents (Institutional Services Committee, 1976). By the mid-1960s, Florida's four Sunland Training Centers were all at or near their capacities of 650-2100 patients (Table 2). However, 14 smaller, private facilities had also sprung up in response to growing public dissatisfaction with the state facilities (Milligan, 1965).

In January 1966 the Miami area Sunland Training Center was dedicated with much fanfare. Governor Haydon Burns called the center: "...physical evidence of Florida's determined effort to provide adequate facilities for our mentally retarded." Mrs. Rose Kennedy, mother of the late president, attended and spoke. She told parents of retarded children not to be discouraged, as she herself had given birth to a retarded child and had gone on to have several more children who were normal (*St. Petersburg Times*, 1966).

The Miami Sunland was built on a large campus well north of the city. It expanded within months. By 1969, there were 928 residents at the center, plus many on a waiting list. State officials were quick to point out that more residents could be housed there but for a shortage of qualified personnel to work with the children (Cortazzo, 1969). The next year, the Sunland Center in Tallahassee opened. Like the Orlando Sunland, the Tallahassee center was also placed in a renovated tuberculosis hospital (*Tallahassee Democrat*, 1967).

The final Sunland opened in July of 1968 in DeSoto County, outside the tiny cattle ranching town of Arcadia. The Arcadia Sunland was located at Dorr Field, an abandoned airfield about 12 miles east of town. Patients were housed in former military barracks. From the beginning, the Arcadia Sunland, set in a remote location far from any major population center, experienced serious problems.

In September of 1968, Republican State Senator John Fisher, an obstetrician, visited the center as part of a legislative committee on health and welfare. Fisher then held a news conference and called the center "the most revolting thing I have seen since I

Table 1. Classification of Amentia, 1954

Tentative Diagnosis	Clinical Features
Mild Amentia (IQ 75-100) Dullness, retardation	Trainable and educable; mild delay in development; behaves rigidly; plays unimaginatively; learns slowly; completes elementary and secondary school
Moderate Amentia (IQ 50-75) Moronity	Trainable and educable; moderate delay in development; performs useful tasks without supervision; lacks adaptability to environment; learns reading, writing, and arithmetic
Marked Amentia (IQ 25-50) Imbecility	Trainable but not educable; marked delay in development; understands the spoken word; protects himself against danger; performs routine tasks under supervision
Extreme Amentia (IQ 0-25) Idiocy	Untrainable and uneducable; multiple structural abnormalities; severe functional inadequacies; lacks understanding of self-protection; requires custodial care

Source: Kugelmass, I.N. (1954). *The management of mental deficiency in children*. New York, NY: Grune & Stratton.

Table 2. Sunland Training Centers, 1965

LOCATION	CURRENT CENSUS	CAPACITY	SUPERINTENDENT
Fort Myers	1000	1000	John M. Presley
Gainesville	2040	2106	R.C. Philips
Marianna	401	650	Robert L. Eatton
Orlando (hospital)	871	1000	C.H. Dutcher

Source: Milligan, G.E. (1965). *Listing of residential facilities for the mentally retarded*. Washington, D.C.: United States Public Health Service.

Table 3. Mental Retardation Population Statistics, 1970 – Distribution by Degree of Retardation

Degree of Retardation	IQ	% of Retarded Population	Total Number
Mildly (educable)	52-67	89.0%	178,152
Moderate (trainable)	36-51	6.0%	12,010
Severe	20-35	3.5%	7,006
Profound	1-20	1.5%	3,003

Population of Florida, 6,672,399; Number of retarded persons in Florida, based on 3% of the population, 200,171.

Source: Division of Retardation (1970). *Comprehensive Community Service Programs for the Mentally Retarded in Florida*. Tallahassee, FL: Florida Department of Health and Rehabilitative Services.

Table 4. Number of Sunland Clients Residing in Each Center, 1974

Sunland Center	Number of Clients (N)	Percentage of Total (%)
Marianna	780	14.2
Tallahassee	454	8.2
Gainesville	1545	28.0
Orlando	934	17.0
Fort Myers	944	17.1
Miami	853	15.5
Florida residents	5350	
Out of state residents	93	
Total	5443	

Source: Division of Retardation (1975). *A Profile of Residents in Florida's Sunland Centers for the Retarded*. Tallahassee, FL: Florida Department of Health and Rehabilitative Services.

have been in the State of Florida.” He accused a senator and a representative from southwest Florida of keeping the center open for political reasons. Finally, Fisher pointed out that the state was not distinguishing between mental retardation and mental illness in institutionalizing patients, giving an example of a young woman living at the Arcadia center who had been the valedictorian of her high school class (*St. Petersburg Times*, October 1, 1968). The next month, the Florida Psychological Association joined the call for the closure of the Arcadia center (*St. Petersburg Times*, October 21, 1968).

On May 13, 1969, the Senate passed a bill to close Dorr Field. At the same time, it was pointed out that there were 1066 people on the waiting list for a Sunland center. Some expressed concerns that it was more expensive to convert Dorr Field to its next planned use, a prison, than it would be to renovate and improve the Sunland center (*St. Petersburg Times*, May 14, 1969). The location closed later in 1969 and was indeed repurposed into a state prison that remains today.

AGING RESIDENTS AND CALLS FOR CHANGE

The 1970s saw growing controversies concerning the appropriate role, if any, of institutionalization. Nationally, a number of scholars and journalists sought to describe the problems of state warehousing of the mentally retarded in a way that would drive citizens to action. Not the least of these was the Willowbrook story.

The Willowbrook State School was located in Staten Island, New York. The facility cared for severely mentally retarded children. By 1965, Willowbrook had 6000 patients despite being designed for a capacity of 4000. Robert F. Kennedy toured the facility and called it a “snake pit” (Museum of Disability, 2010). Still, patients continued to be admitted. In 1972, television reporter Geraldo Rivera was invited onto the campus by a staff physician frustrated by the neglectful care of his charges. Rivera took a hidden camera into the school and filmed a documentary exposing the living conditions of residents titled *Willowbrook: The Last Great Disgrace* (Rivera, 1972). The show was broadcast on network television. Despite all of this, the school did not close until 1987, 15 years after its exposure as a place of shocking neglect (ARC of Massachusetts, 2008). However, the scandal led to investigations of other state-run facilities for the mentally retarded.

In 1972, Wolf Wolfensberger, a well-respected academic in the field of mental retardation, published *The Principle of Normalization in Human Services*

(Wolfensberger, 1972). The book further elevated the push toward community based, individualized treatment plans for mentally retarded individuals. By the mid-1970s, most states were finding ways to make use of funds provided by the relatively recent Medicaid program to help set up and pay for services outside of institutions (Trent, 1994).

Two federal laws reinforced Wolfensberger’s work. The *Developmentally Disabled Assistance and Bill of Rights Act* was enacted in 1975 (Florida State Planning Council, 1978). That same year, the *Education for All Handicapped Children Act* was also passed. This law mandated that public educational services be made available to all children between 2 and 22 years of age (Cleland, 1979). Not incidentally, this act also changed the terminology from “handicap” to the more current term “disability” (Ainsworth & Baker, 2004). The Act set in place the foundation for many years of legal actions by parents who were dissatisfied with local educational programs for children with special needs.

In 1970, the Florida Division of Retardation provided estimates of the number of retarded persons in Florida (Table 3), and issued a community services report summarizing the available options for “retardates” in Florida (Division of Retardation, 1970). The report noted that institutionalization was still recommended by 65% of practicing pediatricians. However, problems of inappropriate treatment including abuse continued to rise within the Sunland Centers. One of the most publicized cases was brought to light in 1972, when the superintendent of the Miami Sunland and seven employees were suspended after reports of abuse and punishment of several boys at the center (*St. Petersburg Times*, April 7, 1972). This incident spurred the creation of statewide citizen councils for human rights protection throughout the state that were codified into law in 1975 (Busby, 2001).

In 1974, members of the Select Committee on Retardation spent nine days visiting the six Sunland Centers, culminating in a report that noted “the Sunlands are overcrowded, perhaps by forty to sixty percent according to contemporary standards.” In addition, the committee members noted a high level of internal tension, low morale, and little incentive to work in the environment of the Sunlands (Subcommittee for Institutional and Regional Programs, 1974).

Because patients admitted to Sunland primarily received custodial care, they were not commonly discharged. Thus Sunland residents were aging. By 1974, over 64% of Sunland residents were adults (Subcommittee for Institutional and Regional Programs, 1974). The Florida Division of Retardation

published *A Profile of Residents in Florida's Sunland Centers* (Table 4). For the first time, standardized information was gathered on each patient. This was the first step in finally implementing client-centered, goal-oriented services (Division of Retardation, *A Profile of Residents*, 1975).

By 1975, there were 5510 residents in the six Sunland centers. Of these, only 127 were preschool aged children, reflecting a huge shift from the original purpose of the centers (Division of Retardation, "Education Plan" 1975). Sunland residents included over 1200 non-ambulatory children and adults. Of these, 378 were listed as "does not move," reflecting those residents with such severe disabilities that they could not so much as creep or roll to move themselves about (Division of Retardation, "Education Plan" 1975).

Florida became the first state to adopt a bill of rights for the mentally retarded in 1975. Francis Kelley, the director of the Division of Retardation, said that the bill would allow Florida to "develop the best program in the nation" (*Tallahassee Democrat*, June 4, 1975). That October, Kelley appeared before the Senate Health and Rehabilitative Services Committee. He estimated that 980 patients could be moved to intermediate care facilities immediately if such facilities existed. Kelley and his staff optimistically estimated that the Sunland Centers could be closed in five to six years if the State was willing to share the cost of transferring patients to smaller, intermediate-care facilities (*Tallahassee Democrat*, October 15, 1975). This did not come to pass.

In 1979, a federal class action lawsuit was filed against the State of Florida and Governor Bob Graham over treatment at the Orlando Sunland. Orlando had been investigated for having the highest rate of gastrostomy feeding tube placement of any facility in the country. This method of surgically installing a feeding tube through the abdominal wall was seen as a shortcut to feeding that deprived residents of the pleasure of eating. However, physicians and others working in the center vigorously defended the practice, citing high rates of aspiration and pneumonia without the tubes, due to the severe combined mental and physical deficiencies of the Orlando residents (Ricks, 1989). This disagreement was characteristic in the passions displayed by those on both sides in the ongoing argument about best treatment, each side claiming to most fully understand the patients' problems. As a result of the lawsuit, in October of 1982 a judicial order was issued to close the Orlando Center by July 1, 1984 (Association for Retarded Citizens, 1984).

NEW IDENTITY OR DISSOLUTION

In 1980, Congress enacted the Civil Rights of Institutionalized Persons Act. This act created the ability for the Department of Justice (DOJ) to become involved in protecting the rights of residents of state institutions (National Council on Disability, 2005). The law authorized the Attorney General to initiate lawsuits in federal court to represent people in jails, institutions for people with psychiatric or intellectual disabilities, and other such facilities. These individuals were identified as being especially vulnerable to abuse. The law was intended to assist in forcing correction of "egregious and systemic violations of the rights" of such persons. Protecting vulnerable individuals would continue to be an important DOJ responsibility for many years.

With the passage of the Developmental Disabilities Assistance and Bill of Rights Act of 1984, the focus on community treatment was fully legitimized. This act specified that persons with mental retardation should use the same community resources available to other citizens, participate in the same community activities, and reside in homes or home-like settings close to community resources (United States Congress, 1984). The de-institutionalization movement started in full force throughout the country, with numerous bumps along the way.

By the early 1980s, Florida's leaders planned to close the Sunland Centers and move patients to smaller, grouped, more home-like facilities called "cluster homes" in various locations around the state. The Orlando and Tallahassee Sunland Centers were specifically targeted for closure because of the deteriorating condition of the former tuberculosis hospitals. However, moving the most severely disabled residents out of the Sunland hospitals carried significant risks. In the early 1980s, a number of patients from the Orlando Sunland were moved to a cluster home. Nine patients died within a few months of transfer, prompting a State investigation into the center. However, by the mid-1983, seven cluster homes had been opened, and patients were leaving the Sunland Centers at a rapid pace (Doyle, June 19, 1983).

Advocates for the mentally retarded in Florida faced considerable roadblocks in the 1980s in their attempts to move residents into community settings. In September 1980, the Gadsden Association for Retarded Citizens (GARC) won an effort to move eight mentally retarded women into a new group home in Quincy, which had been strongly opposed by residents living near the proposed site. One week after their victory, GARC found out that their long battle had been futile. They were told that the state was

unable to fund the project as planned due to a severe budget deficit (Bracey, 1980).

However, some gains had been made. By the end of 1983, the number of patients being served in the Sunland Centers had dropped by almost 60%, from over 6000 residents in 1971, to 2588 in 1983. Overall, Florida's use of all such facilities, including intermediate care facilities (ICF/MR) and Sunlands, was dropping, with more patients being maintained at home (57%) than in a cluster home or Sunland (43%). Things were improving slowly for those now sometimes termed "developmentally disabled" in State reports (Florida Developmental Disabilities Planning Council, 1984).

From the beginning of community-based residential care, there was much debate about the adequacy of payment for services. As the 1980s progressed and more ICF/MR and other community settings opened, the disparity between the costs of care and the rates of reimbursement seemed to be growing. A study showed that group homes were indeed operating at substantial deficits. The investigators found that some of the small "family" providers were working seven days per week with little sleep and approaching bankruptcy from trying to meet the needs of the state's Developmental Services clients. The final estimate: an additional \$9.6 million per year was needed to fund the services being provided (Jacoby & Woodsmall, 1987). Again, acknowledging a problem and funding the solution did not go hand in hand.

Three of the remaining six Sunland Centers either closed or were renamed in an attempt to gain a new identity apart from the legacy of Sunland. In November of 1982, the Miami Sunland Center changed its name to Landmark Learning Center. Ulysses Davis, the center's new superintendent, acknowledged that changing the name was an attempt to set the Miami center apart from the five other Sunlands (Zaldivar, 1982).

At the time of the name change, the Miami center still had 400 residents. In early 1985, Florida Health and Rehabilitative Services (HRS) recommended to the governor that Landmark be closed and its clients deinstitutionalized. However, the state senator from Miami promised residents and employees that the center would remain open for at least another year (*Miami Herald*, May 15, 1985). Eighteen months later, the story had changed again. In November of 1986, the Florida Legislature ordered that 60 retarded clients be moved to group homes in the community, moving toward a complete closure of the center (*Miami Herald*, November 29, 1986). In the end, Landmark remained open for another 19 years.

In 1983, the Tallahassee Sunland Hospital was closed and the patients dispersed to group homes around the state. The other Sunland hospital in Orlando was ordered to be closed by July 1984 following a protracted lawsuit citing care deficiencies. At the time, the hospital still had over 500 patients. The practicalities of transferring out this many severely disabled residents, coupled with several deaths of former Orlando residents in cluster homes, prevented the deadline from being met. The hospital finally closed its doors in 1985 (Ricks, 1989).

REORGANIZATION AT EVERY LEVEL

On July 26, 1990, Congress approved the Americans with Disabilities Act (ADA). This extensive and far-reaching law prohibited discrimination on the basis of disability by state and local governments or commercial enterprises. Specifically, Title II of the ADA prohibits discrimination on the basis of disability by state and local governments and their contractors (Ainsworth & Baker, 2004).

In the recording of the law it was noted that: "Historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem" (United States Department of Justice, 2010). The passage of the ADA has had a continuing profound impact on state policies concerning institutionalization and the ongoing oversight of the care of those with intellectual disabilities.

On June 22, 1999, the Supreme Court ruled in *Olmstead v. L.C. and E.W.* that failure to provide integrated community-based services due to inadequate state funding was a *per se* violation of the ADA (Cornell University Law School, 2010; Atlanta Legal Aid Society, 2010). This landmark case had a significant impact at both the national and state level in advancing decisions to move institutionalized persons into the community.

Florida continued to struggle with how to provide proper care and funding for institutionalized individuals. In 1992, the director of Miami's Landmark Learning Center resigned, and the local paper noted that "too many brutalities occurred on his watch at the state facility for the developmentally disabled for him to stay." Jim Towey, then the secretary of the HRS, promised to make changes at the facility, which still housed 350 residents (*Miami Herald*, December 19, 1992).

One month later, HRS pulled 36 mentally and physically disabled clients from a chain of Dade

County group homes after allegations of abuse, neglect, and misuse of state funds and clients' money (*Miami Herald*, March 12, 1994). All of the residents were moved into the Landmark Center. Two weeks after that, the State was again discussing how to close Landmark, raising fears of parents and advocates about what the options would remain for the residents (*Miami Herald*, March 21, 1994).

In 1995, the Department of Justice Civil Rights Division investigated Landmark Learning Center, focusing "specifically on allegations concerning abuse and neglect of residents, inadequate medical and psychiatric care, failure to provide residents with adequate training programs, and failure to provide services to residents in the least separate, most integrated setting" (Patrick, 1995).

In 1990, the oldest Sunland center changed its name from Sunland Gainesville and became known as Tacachale. The name was chosen from a Timucuan Indian word meaning "to light a new fire" and signified a new start for the center (Agency for Persons with Disabilities, 1990). Several years later, the Fort Myers Sunland also selected a new name, becoming the Gulf Coast Center.

By 1998, there were four Sunlands or institutes formerly known as Sunland remaining. That year, a group of residents confined to the four centers along with their advocates filed suit against the State of Florida, its officers, and the heads of the Sunland Centers. The lawsuit alleged that the State was in violation of the Americans with Disabilities Act, the Rehabilitation Act of 1973, the Social Security Act, and the Due Process and Equal Protection Clauses of the U.S. Constitution, among other grievances. The suit was certified as a class action in 1999 after Governor Jeb Bush took office and it became known as *Brown v. Bush*. After lengthy mediation and negotiations, the parties settled the suit in 2004. The defendants agreed to close one Sunland by June 30, 2005 and another by July 1, 2010 (*Brown v. Bush*, 1998). This sealed the fate of the Landmark Learning Center in Miami and the Gulf Coast Center in Fort Myers.

A NEW CENTURY: WHAT REMAINS

In the year 2000, the Developmental Disabilities Assistance and Bill of Rights Act was reauthorized. This law reinforced and expanded the Americans with Disabilities Act of 1990 in securing services for and assuring access to a full complement of community resources for those with developmental disabilities.

In 2008, a report supported by the Administration on Developmental Disabilities showed that Florida had indeed made significant progress since 1980 in de-

institutionalizing intellectually and developmentally disabled residents, with 1148 patients still residing in large residential facilities (Administration on Developmental Disabilities, 2010). This was a significant decrease from the former daily census of 3750 individuals. The report also pointed out that by 2009, 11 states had closed all of their state operated facilities with capacities of more than 16 people (Lakin, Larson, Salmi, & Scott, 2009).

President Obama launched the "Year of Community Living" on June 22, 2009, in commemoration of the 10th anniversary of *Olmstead v. L.C. and E.W.* and to reaffirm a national commitment to enforcement of the civil rights of those with disabilities. The Office for Civil Rights, a member of the DHHS coordinating council, investigated 584 possible violations of *Olmstead* between 2000 and 2010. Of these, 43% were found to involve civil rights violations (Department of Health and Human Services, 2010).

In December 2000, Florida's Advocacy Center for Persons with Disabilities began investigating what they called a "troubling" number of deaths at 60 privately run care centers for the developmentally disabled throughout Florida. The advocacy group began a formal investigation into the deaths of 173 people that had occurred since 1996 at private centers. In response, the director of a 48-bed center for severely disabled adults in Fort Lauderdale pointed out the extreme needs and risks of some patients residing in private facilities. Once again, the reality of caring for individuals with complex needs made an analysis difficult (Miller, 2000).

In October 2004, The Florida Agency for Persons with Disabilities became a separate state agency. The agency now works "in partnership" with local communities and private providers to assist persons and families affected by developmental disabilities, which are codified as spina bifida, autism, cerebral palsy, Prader-Willi syndrome and mental retardation (Agency for Persons with Disabilities, 2010). The independent state Developmental Disabilities Council conducted an investigation in 2008 of the impact of state budget and service cuts on persons with disabilities, finding that families were not receiving adequate funding for services needed. The report acknowledged that the legislature had enacted the cuts as a means of reigning in spending, but that the state had "undercut the mainstay of its service approach, putting in jeopardy patients and families" (Melda, Smith, & Agosta, 2008).

At the close of the 20th century, Florida was again struggling with the appropriateness of clustering large numbers of developmentally disabled residents

together. State laws prohibited special-needs facilities from being established within 1000 feet of each other. A bill to rescind this law so that developers could create larger clusters of homes and “intentional communities” for the disabled was introduced in 2010. The bill was passed and signed into law by Governor Crist on June 3, 2010 (Parents Planning Programs, 2010).

In 2005, Landmark Learning Center, the former Miami Sunland, was closed, followed by the Gulf Coast Center in Fort Myers in 2010 (Miami-Dade County, 2010). Both the Miami and Fort Myers centers met the closure deadlines established in *Brown v Bush* several years earlier. Today, there are two public long term care facilities for intellectually disabled adults in Florida. Only the Marianna Sunland continues to carry the Sunland name. Tacachale, the Gainesville-based facility, is the site of the old farm colony established in 1919. Each facility houses over 400 intellectually disabled adults. A wide variety of public and private partnerships share the task of meeting the needs of intellectually disabled children.

CONCLUSION

Developmental disabilities of one kind or another affect about one out of every six children in the United States (Centers for Disease Control and Prevention, 2013). These conditions create significant financial and social costs to families and society. Considerable dissension still exists about the appropriateness of institutional care for even the most profoundly disabled individuals. Is there a role for larger group settings to better enable the provision of the multiple needs of these citizens? Experts continue to disagree, pointing out the difficulties of managing of such a wide variety of disabilities (Metzel, 2004; Tyor & Bell, 1984). The fact remains that some of the most ardent supporters of providing some level of institutional support have always been the families and caregivers of the institutionalized.

One striking effect of the de-institutionalization movement was a shift in perception of duty and responsibility for these residents, but did it responsibility of the state actually change? By moving Sunland residents from public facilities to privately owned and operated ones, the perception of the State's role shifted from that of perpetrator in the case of abuse or neglect, to one of overseer and rescuer of vulnerable people. In fact, the actual responsibility for the former Sunland residents never changed, just the ownership of the facilities in which they resided.

It may indeed be true that we are “nearer to the beginning than to the middle in understanding development in the care of people with mental

retardation” (Burack, Hodapp, & Zigler, 1998). The era of the Sunland Training Centers was defined by expansion of knowledge, controversies in treatment, and fundamental changes in national and state laws addressing persons with disabilities. The history of these facilities serves as a useful reminder of the many implications of institutional care, and a point of contrast for designing future care models.

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