

DEPARTMENT Public Welfare

STATE OF MINNESOTA

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cc: JC
Office Memorandum

TO : Medical Directors and Administrators
Hospitals for the Mentally Ill and the Mentally Retarded

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The attached paper was prepared by Mr. Wrobel for the Residential Care Subcommittee of the Health Task Force of the Governor's Council on Health, Welfare and Rehabilitation.

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FUTURE MODES OF PROGRAMS FOR MENTALLY RETARDED IN STATE RESIDENTIAL FACILITIES

For Residential Care Subcommittee of the Health Task Force
Governor's Council on Health, Welfare and Rehabilitation

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The question of what I'd like to see in state residential facilities for mentally retarded in the future is like asking me what I'd like for Christmas. The question is an interesting one, and I would like to free-associate, shall we say, because in order to get at the root of the problem, I can, at the same time, be relieved of the mechanical and implementational problems that ordinarily dictate future course of events. This allows me to zero in on what programs and services mentally retarded persons need generally and what do the state residential facilities need to provide specifically.

If we begin by agreeing that mentally retarded persons can learn, and that they can perceptively benefit from a variety of services and experiences that are ordinarily associated with the normal community, we can predict certain needs in future use of state institutions for the mentally retarded. If we put the mentally retarded person in the category of needing only custodial care because he cannot learn or improve in functioning, then the rest of this paper consists of inappropriate projections of future program needs for the mentally retarded.

Based on my conviction that mentally retarded persons can learn and benefit from services, and that they are more like us than they are unlike us, then we would have to say that the majority of mentally retarded persons are the way they are because we have not, historically, provided sufficient learning and social experiences needed. At the same time the professionals in the field are just beginning to understand how the mentally retarded learn and what needs

to be done to teach in a meaningful way. The problem cannot be reduced to such simple concepts because the business of providing a sequence of services needed in order to develop mentally retarded persons to the limits of their ability is very complicated.

We have rather reliable evidence that mentally retarded persons can improve their functional ability if given opportunity to learn and medical treatment to reduce physical handicaps. Can the mentally retarded person's mental condition be changed? Perhaps not, but we can alter his functional ability by getting him to make better use of the intelligence he does have.

Is this too optimistic? It may be, if we use past history as a point of projecting, rather than recent evidence of results.

What do we need to do? I believe that we need a clear-cut planned situation where the placement of mentally retarded persons is based on the needs of the particular person, and availability of such services that will predictably improve his functioning level. This would first require sharing of costs between the state and county welfare departments on, perhaps, an equal basis, so that placement decisions are based entirely on what's best for the individual rather than cost factors influencing the decision. Since it is desirable that mentally retarded persons be cared for in the community and by the community as much as possible, a kind of counter-influence is evident when cost to the public through the county welfare departments is much higher than the cost of care in the institution. County welfare departments have to pay the full cost of services in the community and only 10 per cent of the pro-rated costs in the institution. This situation often results in placement in an institution when it is more advisable that the retarded person be programmed in his community.

Legislation to correct this situation will be introduced in the next legislative session and is a key factor in the future development of programs in the institutions. It is strongly recommended that such legislation include requirement that program standards be established for all mentally retarded persons based on categorical levels of functioning applicable to both state institutions and community facilities serving the mentally retarded.

Program standards need to include the determination of location of facilities in relation to available medical, diagnostic, vocational, educational, and recreational services for persons living there. Such residential facilities cannot be isolated from community services as institutions historically have been.

I hold to the principle of care close to the patient's home and program opportunities. We need to evaluate the "close to home" principle if it excludes opportunity for programming in social and vocational training, medical care, recreation, etc. This clearly implies that we need to evaluate our discharge policies that may be resulting in placement of patients in situations that offer less training, medical, social, recreational opportunities than such persons need. We will need to improve our community services to insure that mentally retarded persons are not simply existing close to their homes without adequate service opportunities. I believe that the sharing of costs legislation would be a step in the right direction.

If we think of programming the individual person through various facilities and services that are, or may become, available, then we have to put the institution in proper perspective to all services and look at what point in a person's life is it critical that he be programmed in a special institutional program to insure highest level of functioning. In other words, what services will the community use the institution for if one can elect to place the patient in an institution or a community facility for a specific course of training without regard to the cost differential?

This is tough because it begs prediction of future conditions. At best, we can make a few educated projections based on previous experience and current levels of service. For example, institutions staff are becoming rather sophisticated in several areas of program services for at least a portion of the patient population. In order to assure a situation where all patients are programmed according to their needs, staff will need to be better trained, space made available for increased services, smaller group living units established, and more staff employed.

State hospitals should be thought of as a community resource for the public with strong emphasis on designing training and medical rehabilitation rather than custodial services. This, together with increased development of various community services, will greatly improve the resources available to the county welfare departments in carrying out legal responsibilities for the mentally retarded in their county.

The population of the institution is changing because of developments of various kinds of community services---for example, daytime activity centers, sheltered workshops, special education classes in the public schools and congregate care homes. Public awareness and acceptance of its responsibility for care of mentally retarded in the community has increased significantly, making the community a more comfortable place for mentally retarded persons to live and work. This, I believe, has decreased demand for services for certain categories of mentally retarded persons, especially the upper level in state institutions.

Concurrent with this, various kinds of relationships have been developed between the institution and community agencies that are resulting insignificant improvement in state hospital programs. For example, through the Department of Education we are developing educational programs in each hospital under Title I.

of the Elementary and Secondary Education Act; vocational evaluation and training programs have been greatly increased by the Division of Vocational Rehabilitation; an MDTA training program for 80 mentally retarded patients has been concluded through close cooperation of local vocational schools, employment security offices, the Division of Vocational Rehabilitation, and the Department of Public Welfare. We are now in the process of studying institution-education programs through the Minnesota National Laboratory of the Department of Education in order to develop better learning opportunities for all residents and plan for future programs. Foster grandparent programs are being developed in all of the institutions through the Minnesota ARC, increasing the personal relationships with residents.

This spirit of cooperation between various public agencies has materially helped state institutions in getting many of the upper level mentally retarded persons back into the community as working and tax-paying citizens. Other less capable patients have improved their functional level so that the community is better able to care for them. The types of patients remaining in the institutions are principally trainable and severely retarded children and adults whose multiplicity of physical and learning problems require higher concentration of services.

Such developments indicate the future type of services that institutions will be called on increasingly to provide. Some of these people may benefit only from traditional custodial care, but the vast majority will likely benefit much more from a sequence of training and medical services planned on an individual basis according to his particular needs.

It appears to me that state institutions will be called on with greater frequency to provide specific services for the following categories of mentally retarded persons:

1. Profoundly retarded children and young adult bed patients
(Older patients are likely to be placed in nursing homes if available). Such a program would need a dynamic diagnostic and medical rehabilitation program that would address itself to mobilizing patients as early as possible.
2. Trainable children and adults--these patients would need a high concentration of physical and social developmental programs, vocational training, learning classes, hand skills, etc., for return to community employment in workshops and other residential centers tailored to their needs.
3. Severely retarded ambulatory children and adults--this group would also require diagnostic services and a variety of therapeutic learning programs similar to group 2 above, in order to intervene in the patient's disability sequence as early as possible. Return to the community would be a prime objective.
4. Educable children with emotional and behavior problems. These persons will need a high degree of therapeutic, educational and vocational services in order to return them to the community as quickly as possible for continued involvement in special education classes, vocational training and employment. The principal facility here would be the Owatonna State School, but consideration should be given to the Minnesota Residential Treatment Center and Adolescent Psychiatric Units in MI hospitals for coordination of services to mentally retarded.
5. Educable level adults with emotional and behavioral problems should be treated in mental illness institutions on an integrated basis to the extent that they can benefit for such psychiatrically

oriented programs. For those whose problems are related more closely to social and vocational handicaps, and physical disabilities, segregated units will need to be established in the MI institutions or the MR institutions, or both.

To the extent that mental illness institutions can develop special programs for the above on a segregated unit basis, such programs should be further encouraged, as is now being done through CHAFF---BR. Population projections for the 1970-71 indicate that there will be a continued drop in population in MI institutions, opening new opportunities for special unit programs for the mentally retarded.

Probably because community services have been able to deal fairly effectively with the less severely retarded persons, the institutions will be getting more severely retarded persons with complicated physical, neurological and training problems than they did several years ago. This, I believe, indicates our future function, and if we are to improve their functional level in a planned, deliberate way, a higher concentration of skilled staff, more services, and space will be needed.

For these reasons it would appear that the following projections can be made:

1. There needs to be a sharing-of-costs law which would not financially penalize county welfare departments in developing a sequence of services needed for a particular individual. This should include provisions for sharing of costs with the patient's family in order to keep him at home, if this is desirable.
2. Most large patient buildings in the institutions will need to be converted into small patient group-living units which will further reduce bed capacity. (A few dorms may be needed.) This should

include adapting certain units for use by children, bearing in mind that approximately one third of the patient population in the MR institutions is under 21.

3. We need to establish rehabilitation space standards in addition to Department of Health's hospital standards for bed space. This, together with creating small group living units, may reduce a 1500-bed capacity hospital to 900 to 1000 beds in order to accomplish such a specialty function.
4. Program standards will need to be established for the various categories of mentally retarded persons, and they need to be applicable whether the MR person is in a community or institutional setting.
5. Increased emphasis on the employment of professional teachers, occupational, recreational, and music therapists, physical therapists, speech therapists, rehabilitation nurses, vocational training staff, counselors, social workers and psychologists. This needs to include the establishment of diagnostic services that cannot be provided before the patients get into the institution and diagnostic services that are needed on a continuing program basis.
6. More medical rehabilitation staff of specialists will be needed to develop programs for the physically disabled, conduct research, and carry on continuing diagnostic evaluation.
7. Establish a health service with appropriate physician-patient ratios in order to carry out better family physician type medical services.
8. Stronger liaison with other community agencies in order to improve the quality of services to patients, including Division of Vocational Rehabilitation, Special Education, University of Minnesota, state colleges, employment offices, vocational training schools, medical schools, and schools training occupational therapists, recreation therapists, music therapists, and teachers.

It should be clear that the institutions are not to perform a custodial function because, in most respects, the communities would be better equipped to do this. Institutions should be developed into the best concentration of medical and training services in order to provide a service that will return the MR to the community in better shape and better able to cope with community living and to raise the functional level of those who cannot cope with community living.

It is desirable that MI institutions develop MR services separately from the mentally ill patients in order to effectively deal with the varied developmental, educational and medical needs peculiar to the mentally retarded.

Those persons served on an integrated basis should be intelligent enough to cope with the social structure of that particular unit and who can benefit from psychiatrically oriented services.