Comments solicited by MN ARC regarding regional multi-disability institutions – November – December 1968

CHILDRENS HOSPITAL OF LOS ANGELES

4650 SUNSET BOULEVARD • LOS ANGELES, CALIFORNIA 90027 • 663-3341

November 12, 1968

Mr. Peter Shrum
Program Analyst for Harvey H. Glommen
MINNESOTA ASSOCIATION FOR RETARDED CHILDREN, INC.
1911 Nicollet Avenue
Minneapolis, Minnesota 55403

Dear Mr. Shrum:

Thank you for your note about your new plans for Minnesota. It is very difficult to evaluate these plans without a thorough study to assess the capacity of the mentally ill hospitals to program for the retarded. I believe you should demand that such a study be done. The changing role of hospitals also affects these decisions as well. I'd rather that your state spent dollars on community services rather than remodeling outmoded buildings.

I am sorry I can't be of more help.

Sincerely,

RICHARD KOCH, M.D.
Director
DIVISION OF CHILD DEVELOPMENT

RK:gmf

RICHARDS, MONTGOMERY, COBB & BASSFORD

LAWYERS

FRED B. SNYDER
EDWARD C. GALE
FRANK A. JANES
DECEASED

BERGMANN RICHARDS
EDMUND T. MONTGOMERY
NATHAN A. COBB
PAUL L. SPOONER, JR.
CHARLES A. BASSFORD
MELVIN D. HECKT
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MINNEAPOLIS
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November 26, 1968

Honorable Harold LeVander
Governor of Minnesota
St. Paul, Minnesota 55101

Dear Governor LeVander:

As a member of the Executive Committee of your Council on Health, Welfare and Rehabilitation and as a Director of the National, Minnesota and Minneapolis Associations for Retarded Children, I am most distressed, concerned and opposed to the action taken by said Council November 21, 1968 in approving Sections C and D of Paragraph II, Policy Recommendations relating to State Residential Care Programs found on Pages 4 and 5 of the State Policy's plan for the provision of residential care, State of Minnesota and the approval of the recommended cost of care bill as set forth in I, A, Subdivision 1 found on Page 3 of said report.

My objections to the utilization of the seven mentally ill institutions and the three mentally retarded institutions as multiple, regional residential facilities for the mentally ill, mentally retarded, drug addicts and alcoholics, certain elderly and physically handicapped and possibly juvenile delinquents are as follows:

1. No state or country to my knowledge has successfully integrated the mentally retarded with the others listed in residential living quarters.

2. Pressures for placement will result in placement of handicapped human beings in residential facilities not designed or suitable for the development of children or adults but rather continuation of their placement in buildings which guarantee total lack of privacy, program and development.

3. Legislative pressures to save money by utilizing said existing institutions will prevent the development of residential care facilities in communities having large populations such as Minneapolis, St. Paul, Duluth, Rochester, St. Cloud, Fargo-Moorhead and others and this will defeat the recognized principle contained in this report that the retarded for example should live within their own communities or as close to their home communities as possible.

4. None of the recognized experts in the field of mental retardation including the President's Committee on Mental Retardation, the National Association for Retarded Children, the American Association of Mental Deficiency have endorsed or approved such a plan.

5. There has not been sufficient research or experience with either the St. Peter or Hastings integrated programs to warrant further expansion into other state institutions.

   State residential facilities for the retarded should be developed now according to modern architectural and programming standards of the Scandanavian type in Minneapolis, St. Paul, Duluth and Rochester as a start and then later expanded in other cities within our regions.

6. Some of our state institutions for the mentally ill would make better junior colleges than facilities for the mentally ill and mentally retarded.

7. At present only mentally retarded persons who have a mental illness in need of treatment should be transferred to mentally ill institutions.

8. There are many, advantages of locating new residential facilities within our cities;

   a. More involvement of the University of Minnesota and our state colleges is essential for the provision of man power and program development within our existing institutions.
   b. More involvement of our qualified and expert medical community found in our cities is of vital importance to such programs.
   c. There is more availability of skilled, professional people in medicine, psychiatry, psychology, social work, rehabilitation and education.
   d. There is more availability of other non-professional staff which could result with training and the employment of some of our unemployed and handicapped people who now reside in our cities.

9. The two so called advantages of utilizing existing institutions as multiple regional facilities namely:

   1. Avoiding cost of building new facilities (this is not well documented or researched and is I am sure fallacious on any reasonably long term basis) and secondly, retention of existing staff (this is not

necessarily supported by research or sufficient data in view of the high turnover of staff and difficulty of recruiting staff in certain of our areas) are completely overshadowed by the necessity of providing Payn, regional ~~proper~~ residential facilities and programs for the above listed handicapped people.

Your Council approved the following Cost of Care proposed legislation approved by the Department of Public Welfare which proposal reads as follows:

* * * State will reimburse counties at rate of 50% or more of net cost to county of. care for retarded individuals under 18 years of age in any licensed facilities. * * * Estimated cost to State $1.9 million.)

The Minnesota Association for Retarded Children and I are of the opinion that the State should reimburse counties at the rate of 90% of the cost of care for retarded individuals of any age in any licensed facility; that the county should pay 10% of the cost of care of such retarded individuals; that relatives on an ability to pay basis should legally be required to pay the counties'10% share for retarded individuals under 21 years of age and the parents and relatives should have no legal responsibility to the State or County for payment of cost of care after the retarded person reaches the age of 21. This is basically with some modification the present plan for retarded individuals who reside in state institutions for the retarded.

My objections to the Department of Public Welfare's proposal as approved by the Council are as follows:

1. To meet the unanimous goal of placing retarded who must live outside of their homes, in their own home communities or as close thereto as possible of necessity means that many residential facilities must be operated in many regions in our state. This will take the very best of planning and development by both state and private enterprise to accomplish.

2. Private enterprise will not fill any or very few gaps in this development if it must rely on the counties for 50% of the cost of care for the reason that real estate taxes are in large demand to meet education needs and there are no counties including my own Hennepin to my knowledge which would in fact match state aids of 50% to provide for such care.

3. Wayne Jacobson whom you appointed to your Council and other nursing home operators have advised me that nursing homes developed in Minnesota because of the fact that 80% of cost of care came from Federal and State funds and only 20% from County funds and further that if the operators would have had to rely on Counties producing more

than 20%, let alone any 50%, of the cost of care, very few if any nursing homes would have been developed in this state.

4. Counties will continue to apply pressure on our state institutions for admissions of their residents if the counties continue to pay $10.00 per month when the patient is in the state institution as opposed to total cost if the patient is in a non-State owned institution. Of course under present law the counties can pass this entire cost on to the parents who in most cases unless they be extremely well to do cannot afford such a burden.

5. One cannot rely on Aid to Disabled funding laws for residential care for mentally retarded persons over 18 as a solution. I personally know of a number of instances where parents transferred their 21 year old or over children to private institutions near home from state institutions, who then found after such transfer for the first time that the county was insisting upon collecting the entire cost of care from these elderly or middle aged parents who could not afford this tremendous burden whereas, when the over 21 year old was residing in the state institution, there was no legal responsibility for the cost of care therefore. Thus, if the parent is extremely poor or extremely rich, the Aid to Disabled program works, otherwise, it doesn't.

6. As a result of the present funding of cost of care we thus have a plan at the present which sends children under 18 years of age to state institutions none of which are designed or staffed for children according to modern standards and knowledge and a program which sends over 18 year olds into many private facilities where work opportunities and training, recreation and social opportunities are not present. I submit this is not modern expert planning for the retarded but false economy from both the human and economic point of view.

In conclusion, Governor LeVander, I believe that these two actions taken by your Council were adopted for the following reasons:

1. It is being expoused by your Commissioner of Public Welfare and other members of the executive branch of government that both you and the legislature are unwilling to expend any increased appropriations for the handicapped and are insisting upon utilizing mentally ill institutions for mentally retarded and other handicapped people and further that you and the legislature will insist upon a 50% state aid for cost of care. Frankly, I do not believe that you as my Governor of my State and Party are taking this position.

2. Commissioner Hursh is opposed to the 90/10 cost of care plan because he says he has tried in the past and failed and you, Governor, don't want it and would be embarrassed if it were approved by the Council or the Legislature. The 90/10 cost of care bill did pass both the House and Senate Welfare Committees last session which was the first time it passed both Houses. It failed in the Appropriations Committees.

3. Commissioner Hursh has resisted the formation of a separate division of mental retardation and as a result is not keeping up with other states in this respect and does not have the quality and quantity of staff to do sound progressive up to date planning for the retarded. Thus, it is easier to do that which may be easiest to accomplish as opposed to that which all recognized experts in the field of mental retardation know to be right.

I am of the opinion that it would not be in your or the State's or the handicapped's best interests to turn back the clock and adopt unsound, outdated, residential care programs for the retarded and other handicapped citizens of Minnesota.

Very truly yours,

Melvin D. Heckt

P.S.

Enclosed please find letter dated November 14, 1968 from Dr. Gunnar Dybwad, Professor of Human Development, Brandeis University, formerly Executive Director, National Association for Retarded Children to Mr. Peter Shrum.

The Florence Heller Graduate School for Advanced Studies in Social Welfare

BRANDEIS UNIVERSITY

WALTHAM, MASSACHUSETTS 02154

November 14, 1968

Mr. Peter Shrum,
Program Analyst
Minnesota Association for
Retarded Children
1911 Nicollet Avenue
Minneapolis, Minnesota 55403

Dear Mr. Shrum:

In half an hour I shall leave for a week's assignment in California and this is my only opportunity to answer your letter which, unfortunately, arrived at a time when I was on another field trip in Nebraska.

You asked for my comments on the memorandum from Arthur S. Funke, dated September 23, 1968. My comment is simply that this is an extremely superficial memorandum written by a person who is thinking of organization rather than people, and of structure rather than program. If Dr. Vail would have lived up to his published opinions which I greatly respect, he should have sent the memorandum back to Funke and told him to do his home work more thoughtfully.

The memorandum from Ardo Wrobel, dated October 21st, is far more satisfactory. while he is leaving open the relative merits of combining several services into one complex of buildings and one overall organizational structure, he makes a good <u>initial</u> point for program integrity and I think this is the first and major peg on which we have to hang our hat.

There is a great deal of loose thinking about various plans for combining services for various types of people with handicaps and the basic weakness is that the fact that we have successfully placed together both mentally ill and mentally retarded and people with other handicapping conditions into a certain workshop or into a hostel or into a recreational program, does, of course, by no means imply that therefore you can mix groups and, in your case,large groups of mentally ill and mentally retarded and people with other handicaps on a 24-hour-day basis. For instance, it may be quite desirable to have certain selected mentally ill and mentally retarded persons work in a sheltered workshop along side each other but that is for the working hours and for these particular people you might want to have, at the same time, insistence on separate living quarters - this is so elementary that one almost hesitates to write it down but Mr. Funke proves that it still needs to be written down.

In other words, placing people into joint programs or mixed programs is a matter of individual decision and the individual decision can be made only from a specialized unit where you have specialized personnel. The idea that in one hospital a man who knows about mentally retarded now begins to accept mentally ill people and becomes responsible for that programming and in another setting the man who has had exclusive

experience with the mentally ill suddenly takes over programming for mentally retarded, is typical of the medical arrogance which proclaims that once you have gained a doctorate in medicine, you can do anything.

To show you that others share my questioning of the claim of the medical people and do so also with regard to your particular State Department, I am sending along an excerpt from a just published book by Robert H. Connery: "The Politics of Mental Health", published by Columbia University Press in 1968, the price is $10.00,and I think it would be well worth the price for your Association, as you undoubtedly will recognize from the excerpts I am sending along.

What concerns me most about this whole plan is that the State Department might be tempted to sell it as a "new solution" when actually it is, at best, a temporary patched up job on a structure that has long outlived its usefulness and, under the term structure I wish to include in this context not only the administrative structure of the services in Minnesota but also the programming and, in particular, of course, the buildings and again I realize that many people have emphasized this in greater clarity and detail.

To underline Mr. Wrobel's last point, I am sending along a statement I recently drew up at the request of the Massachusetts Department of Mental Health for buildings to replace two totally outworn buildings housing the most severely retarded men and women respectively. These guidelines have been enthusiastically endorsed on the regional level and will be presented this coming weak to the Mental Retardation Construction Advisory Council on the State level and several members there have already committed themselves to this new plan. It will also interest you that Illinois which until the recent past ranked at the very bottom in the country in terms of residential services, is developing right now a new facility for severely and profoundly retarded with individual houses, not just units within houses, serving eight residents. If you are interested in further information about this, I suggest that you talk to Mr. Lawrence Bussard, Assistant Director, Division of Mental Retardation in the Illinois Department of Mental Health, 401 South Spring Street, Springfield, Illinois 62706.

I think there is a real danger that Minnesota is falling more and more behind as other States venture forth into new and imaginative planning for the mentally retarded. For instance, I have been very much impressed with what is going on in Nebraska and particularly the new plans for Omaha spell out some new programming. which frees itself from our old routines. Dr. Wolf Wolfensberger of the Nebraska Psychiatric Institute, The University of Nebraska Medical School, 602 South 44th Avenue, Omaha, Nebraska 68105, would be able to give you further information and let you see some of the reports and recommendations which are already in the process of being implemented.

I am sorry that lack of time prevents me from commenting more in detail please feel free to write me further with additional questions.

Sincerely,

Gunnar Dybwad (E.M.)

Professor of Human Development

GD:cm
(Dictated by Dr. Dybwad
but signed in his absence)

Enc: (9)

DEC 4 1968

The Florence Heller Graduate School for Advanced Studies in Social Welfare

BRANDEIS UNIVERSITY

WALTHAM, MASSACHUSETTS 02164

December 2, 1968

Mr. Peter Shrum, Program Analyst
Minnesota Association for Retarded Children, Inc.
1911 Nicollet Avenue, South
Minneapolis, Minnesota 55403

Dear Mr. Shrum:

I have just returned from a week's visit to California where I visited several institutions in northern California at the request of a committee appointed by the Administrator of the California Human Relations Agency to review the State's programs for the mentally retarded (the State Department of Mental Hygiene is part of that Agency). Among the institutions we visited were two hospitals for the mentally ill which had initiated programs for the mentally retarded. From the observations of the team of which I was a member, and from the observations of other teams who visited institutions in other parts of California, I have not gained anything that would make me look with greater favor on the use of hospitals for the mentally ill as temporary or even permanent facilities for the mentally retarded. In fact, we were sorely disappointed with what we saw.

I thought I should mention this to you in case anybody points to California as having successfully utilized hospitals for the mentally ill simultaneously for the care of the mentally retarded.

Very sincerely yours,

Gunnar Dybwad (F.M.)
Professor of Human Development

GD:em

(Dictated by Dr. Dybwad but transcribed during his absence.)

DEC 5 1968

President's Committee on Mental Retardation

Washinton, D.C. 20201
December 3, 1968

Mr. Peter Shrum:
Program Analyst
Minnesota Association for
Retarded Children, Inc.
1911 Nicollet Avenue
Minneapolis, Minnesota 55403

Dear Mr. Shrum:

Dave Ray, Fran Lynch and I have reviewed the proposals made by the Medical Services Division of the State of Minnesota as you requested.

In response to your first question the consensus of personal reactions to the proposed plan was resoundingly negative. However, some of the staff comments may be of value to you in your assessment.

> "I am well aware that there is a paucity of trained personnel available to serve any one group of handicapped individuals. The high cost of replication of services and duplication of effort makes centralization seem our only resource. In several states where such plans were implemented, however, such efforts did not result in merger but an absorption.

> "I am skeptical about the whole concept of regionalization of retardation services in the usual sense of the term. It seems to me that services should be organized according to the incidence of various forms of disability. To expect that all of the retarded can be optimally served in a single catchment area is to overlook the variations in occurences of different types of mental handicaps. For example, the best possible coordinating unit for special education services might be no larger than 6 or 7 suburban school districts while severely retarded blind children might be best serviced on a state-wide basis. To assume that an adequate single geographic area can be laid out to serve mentally retarded, mental health and alcoholic clients, as the Minnesota proposal does, is even more unlikely."

Perhaps at some time in history when mental retardation programs are clearly established as ongoing entities with clear cut identifies and other accouterments such as trained staff, etc.; then the mental health establishment can be given the responsibility of providing care for the mentally ill mentally retarded.

Presently, the visibility of the mentally retarded is too slight to enable the development of a completely congruent program. The too ready pattern of the Short-Doyle Act puts the mental retardation establishment in a defensive "catch up" position.

Furthermore, you begin, in my opinion, with the wrong premise by having a mental hospital as the core of a region.

a. This is in opposition to the community mental health center approach to treating mentally ill and emotionally disturbed.

b. Mental hospitals may have some of the same professional disciplines which serve the retarded--but they are attuned to working with mentally ill and think about people in those terms. The major difference is that mental health manpower works from an educative or training set. The two are opposite--its a rare bird who can switch from one to the other.

c. On the other hand, the skills and knowhow of mental health personnel have not been fully used in treating retarded persons with emotional problems.

d. You could just as well have the regional vocational rehabilitation office or a district health office be the heart of the region, or better yet one of the many colleges located throughout the state.

e. It would seem to me that this plan is motivated by a desire to save the old mental hospitals.

The principal of regionalization is the core of a number of states' approaches such as Illinois, Missouri, and Connecticut. Other states, New York and Pennsylvania have combined mental health and mental retardation boards at the state and county level. It is perhaps too soon to evaluate the efforts of the above since they are all in their developmental stages.

The final criterion of programming or promulgating any plan must be that it serves the person not the system.

Sincerely,

Allen R. Menefee
Deputy Executive Director

DEC 11 1968

THE UNIVERSITY OF NEBRASKA
COLLEGE OF MEDICINE
42ND AND DEWEY AVENUE
OMAHA, NEBRASKA 68105

DEPARTMENT OF PEDIATRICS

December 9, 1968

Mr. Peter Shrum
Program Analyst
Minnesota Association for Retarded Children, Inc.
1911 Nicollet Avenue
Minneapolis, Minnesota 55403

Dear Mr. Shrum:

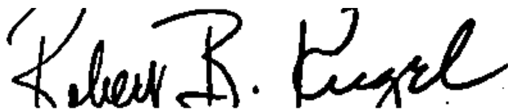
Forgive me for being so late in answering your letter in which you inquire about the plans being made by the Medical Services Division of the State of Minnesota. I have several reactions which I will try to pass along, to you. The concept of regionalization of services is certainly a valid one and many states are confronting this. I would support this idea and I gather that there is no real concern about this matter.

On the other hand the idea of combining mental health, mental retardation and services to the alcoholic all in one setting sounds rather too complex to be workable. The needs of these groups are not identical and I think it does not make the best sense to try to think of them in a single context. Although the evidence is not inconclusive there is some observational information to suggest that those states who have tried to combine mental health and mental retardation activities have not done as well for either group as when trying to provide for them alone. Obviously there should be some interdigitation of effort between these two areas of concern but this does not require that they all be under one roof.

The President's Committee on Mental Retardation will be publishing a rather exhaustive volume on residential care and residential services for the mentally retarded. This book which will be published by the Government Printing Office should be available by the middle of January. The importance of building a community services was particularly stressed and also the concept of normalization and integration of the retarded person back in the community was stressed.

I think you will gain considerable support for your planning groups from this volume. Let me know if I can be of further assistance.

Very sincerely yours,



Robert B. Kugel, M. D.
Foundation Professor of Pediatrics

ss

Establish Separate Iowa Bureau to Aid Mentally Retarded

DES MOINES (AP) — The mentally retarded will no longer play "second fiddle" to the mentally ill in the State Department of Social Services, Iowa Commissioner of Social Services Maurice Harmon said Friday.

Harmon said a separate Bureau of Mental Retardation has been established within the department to seek means of treating in local surroundings persons with abnormally low intelligence.

The bureau's goal Is to make the problem of mental retardation "less tragic" by allowing mentally retarded children to remain with their parents instead of being put in an institution.

The new bureau is one of five in the department's new table of organization which Harmon unveiled Friday to members of the Council of Social Services.

Mental retardation, under the old organization, had been lumped with mental illness where it had "played second fiddie," Harmon said.

Other bureaus in the Department of Social Services, which came into being July 1 as the result of a legisla- tlve reorganization bill passed in 1967, are Adult Corrections, Income Maintenance, Family and Children's Services and Mental Health Services.

"About the only similarity between mental health and mental retardation Is they both contain the word 'mental,'" Harmon told the council, a live-member policy board appointed by the governor.

The new bureau will encourage local school boards to seek local, rather than institutional, help and training for mentally retarded children, Harmon said.

Harmon also told the council that back claims for medical supplies and services under the federal medicaid program are 95 per cent paid.

"This is really a great day," said Harmon who had been faced with a small scale rebellion of s-called "vendors" who demanded payment for claims dating back as far as a year.

The payments are for medicines and drugs and services by doctors, hospitals and nursing homes under Title 19 of the fed. eral Social Security Act.

That program is designed to provide medical care to persons on welfare.

Harmon said the department and Blue Cross-Blue Shield, which acts as the pay agent for the state, are now processing some 80,630 current claims each month but were unable, until recently, to profess claims which came in shortly after the program began in July 1967.

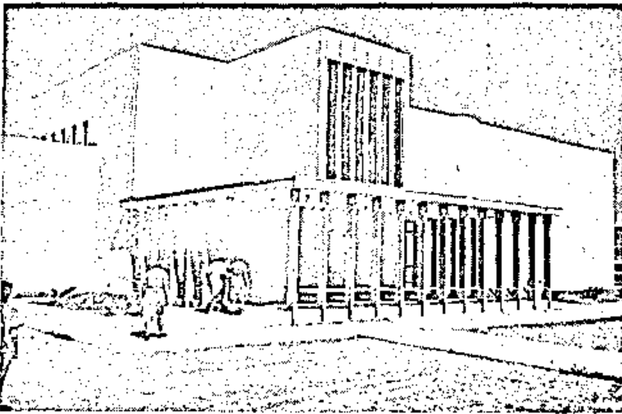
With the disbursement, during the past week, of 20,000 checks to vendors, "we're on top of this now," Harmon said.

SIOUX CITY, IOWA JOURNAL
8/24/68

Bronze Award:

A Special Center for the Mentally Retarded

Colorado State Hospital, Pueblo



Patients from the center regularly use the hospital's new recreation building. Before the center program started, retarded patients seldom had recreation.

COLORADO STATE HOSPITAL has received two Achievement Awards from the American Psychiatric Association. In 1966 it received the Silver Award for sharply reducing its patient census after decentralizing its clinical programs in 1962. The present award is for a program that is an indirect by-product of the census reduction and intensified treatment. Buildings, personnel, and operating resources became available, which enabled the superintendent, Charles E. Meredith, M.D., and his staff to begin planning a special treatment unit for the mentally retarded patients at the hospital.

The Mental Retardation Center opened in July 1965 with 526 patients, who had been scattered throughout the hospital, and a small staff. Robert M. Perry, M.S., a psychologist, has been director of the center since its inception. The administration's belief that a separate, specialized program for those patients would yield results was quickly confirmed. About 90 patients who had been unable to care for themselves were soon trained in self-care skills, and within three months the number of patients assigned to industrial therapy increased from 40 to 170.

IN TIME, many patients who formerly had to be served by personnel at mealtimes learned to carry their own trays through the cafeteria line. Before the program started, only a handful of the patients were in the school program; now more than half attend school, and many more will attend when additional teachers are available. Recreation had been a sometime thing for most of the retarded patients; they now use the hospital's gymnasium and swimming pool regularly, and the center holds weekly dances. In 1964 only a fourth of the retarded patients ever had a visitor; today more than half have visitors.

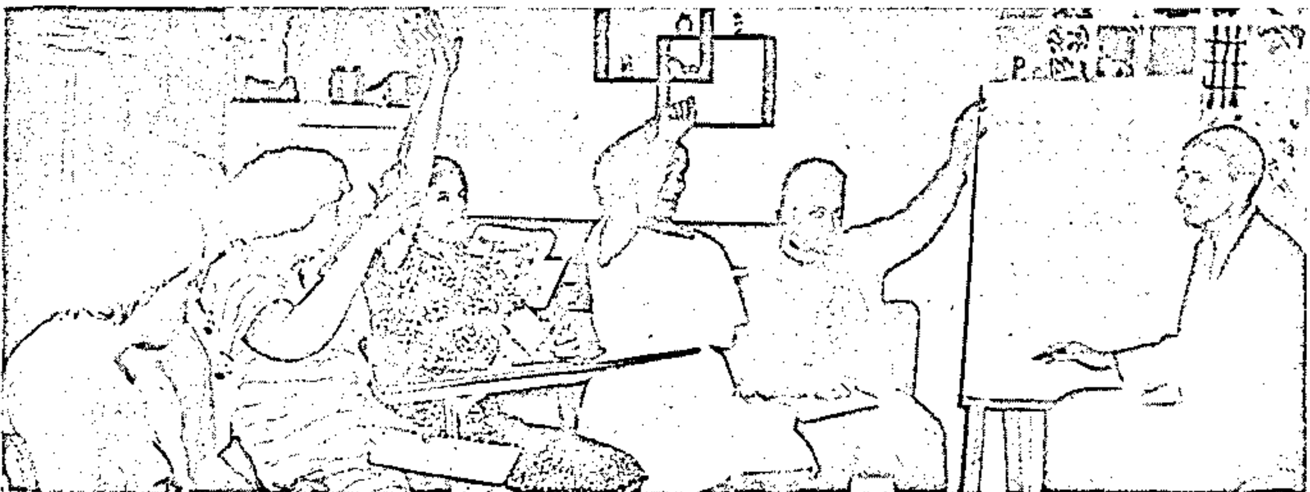
During its first full year *in* operation, the Mental Retardation Center released 106 patients; in the second year, 112 were released. Because older patients made up a large proportion of the center's original population, 44 per cent of the releases were through nursing home placements; that reduced the median age of the patients from 45 to 36. Of the other patients released, 33 per cent were placed on convalescent leave to work part time and live in boarding homes, 19 per cent were discharged to their homes or a job-living placement, and 4 per cent were placed in foster homes. Of the 218 patients released in the first two years, 33 (or 15 per cent) were returned to the center.

The vacancies made possible by releases are filled largely by patients transferred from the state's two schools for the retarded at Grand Junction and Wheatridge, thus reducing their waiting lists. The center admits only patients aged 16 or older; as a rule, they must have an IQ of less than 70 and must not be too emotionally disturbed to benefit from the training program. In 1967 the largest number of the center's patients, 36 per cent, were diagnosed as moderately retarded (IQ 36-51); 29 per cent were severely retarded (IQ 20-35); 16 per cent were mildly retarded (IQ 52-67); 14 per cent were profoundly retarded (IQ below 20); and the remaining 5 per cent were patients of borderline intelligence, with IQs between 68 and 85, who were placed in the program at the center because of their special training needs.

A young patient learns to mend clothes in the hospital laundry as her industrial therapy assignment. Such skills can be used in a community placement.

THE CENTER'S PROGRAM groups patients in living arrangements suited to their need for care and training, yet exposes them to various other persons and situations through the activity programs. The 14 wards are organized into four units: medical, education, training, and preplacement. The medical unit is for patients with serious physical problems and those who most need training in basic self-care skills; most patients on the unit are severely or profoundly retarded. The education unit provides a socially corrective regime for patients with behavior problems, largely teen-agers and young adults; they are closely supervised and must ,earn every privilege and degree of freedom through acceptable behavior. In the training unit most of the patients are heavily involved in the school and work programs; they automatically have privileges unless they lose them through misbehavior.

The preplacement unit is considered the center's "finishing school." It polishes the skills and attitudes a patient needs to live outside the hospital. Patients are encouraged to make their own decisions and to accept responsibility, and above all to want to leave the hospital. The unit lacks some of the comforts and planned entertainments provided by other units. The comforts are omitted to make institutional life seem less desirable to patients who have the potential but not the motivation to leave; the unit's environment also accustoms patients to the



Students in a reading class volunteer to answer the teacher's question. In addition to elementary-level academic subjects, the school program includes vocational training and speech and hearing therapy.

A working patient signs the payroll sheet before receiving his wages in cash. The center also uses tokens to motivate patients to behave responsibly.

style of living they will probably face outside the hospital.

The center's activities are grouped into five programs that serve patients on all four units. The medical program involves the center's physicians. The senior physician directs the medical unit and also serves the education unit; he and the physician assigned to the training and preplacement units function both as psychiatrist and general practitioner. A number of consulting physicians also serve the center. The physicians are responsible for the general health of patients and, when indicated, refer them to the hospital's general medical division for special medical, surgical, dental, or diagnostic work. In addition, if a retarded patient becomes too emotionally disturbed to be treated on his unit, he may be transferred to one of the hospital's psychiatric divisions for as long as necessary.

THE PROGRAM for self-care skills is a responsibility of the nursing service and ranges from toilet-training to behavior-shaping. To encourage patients to develop good habits of grooming, working, learning, and behaving, the staff use operant-conditioning and reinforcement techniques. The center has a token-economy program, in which patients are rewarded for suitable behavior, with tokens that they can exchange for certain privileges or goods.

The school program includes kindergarten-level activities to teach patients how to behave in a class room, academic subjects on the elementary-school level, music, home economics, manual arts, physical education, arts and crafts, and speech and hearing therapy. The school places heavy emphasis on prevocational training. There are six class periods a day, with a maximum of 15 students in each, and the courses are ungraded. The average student spends three periods a day in school, and is expected to eventually achieve a fourth-grade education. Classes are held not only in the school building but also on the medical unit, for patients who are physically unable to go to the school, and on the preplacement unit. A teacher is assigned to the latter unit to work intensively with patients preparing to leave the hospital, and she holds night classes for those who work during the day.

The school teaches patients certain work habits and skills to prepare them for the vocational program, which is called on-the-job training. Trainees are rotated among a variety of jobs in such areas as food service and building and grounds maintenance, to give them experience with diverse tasks, conditions, and personalities. The work supervisors not only teach job skills but also help the trainees learn to be prompt and diligent, to take good care of tools and property, to follow orders, and to get along with co-workers. The levels of training begin with routine tasks, such as mopping floors and making beds, that the more severely retarded patients can perform in the hospital. More capable patients are prepared for unskilled jobs in the community, such as dishwashing and mowing lawns, and the most capable patients are trained for semiskilled jobs, such as being a carpenter's helper or a hod carrier.

THE FIFTH PROGRAM, for placement, involves concentration of the center's resources to aid patients in the preplacement unit. In addition to a teacher, the program has a state vocational rehabilitation worker specially assigned to it; he can place selected patients in the sheltered workshop operated by the State Division of Vocational Rehabilitation on the hospital grounds. For patients who cannot be placed in their own homes or in live-in jobs, the hospital's supportive-placement program seeks care in nursing homes, boarding homes, and foster homes. The Mental Retardation Center is developing its own service to place patients in such facilities, and is stimulating the establishment of placement homes specifically for the mentally retarded.

Besides the five treatment and training programs, the center has within it several services that

relate to all the units. The social service staff obtains information about new admissions, maintains patients' contacts with their families, and helps arrange and supervise outside placements. The psychology service assesses the intellectual and social potentials of the patients, and helps develop the working diagnoses. The recreation service offers activities for wards, units, and the entire center, and also sponsors off-grounds excursions. The nonclinical services include not only such administrative areas as medical records, clerical work, and supplies, but also barber and beautician services. The hospital chaplains provide religious instruction, worship services, and pastoral counseling for residents of the center. The total number of staff members in the center itself is 232.

The hospital staff believe that the creation of the center has also benefited the psychiatric wards where the retarded patients formerly lived. Retardates are frequently more outgoing and demanding of attention than psychiatric patients; the ward personnel now are. free to concentrate on patients with psychiatric problems. Retardates are also typically eager to please, and would volunteer for the ward chores; their removal from the psychiatric wards has stimulated more of the psychiatric patients to assume responsibility. In addition, some of the more manipulative and domineering psychiatric patients, who had been using the obliging retardates as their errand boys and servants, now must do— things for themselves.

The center offers several advantages to the patients transferred from Wheatridge and Grand Junction. A number of them have severe behavioral problems, and are receiving more intensive psychiatric help. Patients over 65 with physical problems are now eligible for financial aid through Medical Assistance for the Aged because they are in a hospital rather than a school. And because the center does not have any patients under 16, the older patients no longer have to compete for attention with infants and young children.

Through inservice training and other continuing staff-development programs, the center has been building a staff that is knowledgeable about and keenly interested in the special problems of the mentally retarded. Their concentrated efforts are making it possible for many patients who formerly would have been institutionalized for life to find a useful niche in society. •