

THE UNDEVELOPED RESOURCE

A Plan for the Mentally Retarded in California

State of California
STUDY COMMISSION ON MENTAL RETARDATION
1500 Fifth Street, Sacramento 95814

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Report
to the Governor
and the Legislature

January 1965

State of California
Study Commission on Mental Retardation
1500 Fifth Street, Sacramento 95814

STUDY COMMISSION ON MENTAL RETARDATION

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January 4, 1965

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Gentlemen:

I have the honor to submit the report of the Study Commission on Mental Retardation, as required by Section 7609 of the Welfare and Institutions Code.

The report is the result of more than a year of study, research and investigation, and it represents the consensus of the Commission members. Our tentative conclusions and recommendations were tested against informed public opinion throughout the state at six regional workshops conducted for the Commission by University of California Extension, and the final report reflects many ideas and suggestions received from over a thousand professional persons and other interested citizens.

The Study Commission recognizes that it has not answered conclusively every question relating to mental retardation in California, as this is a complex and changing subject. We feel, however, that if the principles expressed in this report are accepted and the recommendations adopted, the State of California will have taken substantial steps toward meeting the needs of its retarded citizens and their families. More important than any single recommendation involving direct services, we believe the administrative and fiscal pattern recommended by the Commission offers new hope for effective and humane services to the mentally retarded and other handicapped persons.

Respectfully submitted,

Jack Halpin
Chairman

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PRINCIPLES

The State of California accepts a responsibility for its mentally retarded citizens. Retardation affects hundreds of thousands of children and adults directly and has an important impact on the lives of their families, neighbors and whole communities.

As Governor Brown said in his message to the first meeting of the Study Commission on Mental Retardation, California is a rich state, but it is not so rich that it can afford to waste one iota of its greatest resource: its people.

The Study Commission believes that:

1. Mental retardation is a social problem. Every retarded person and his family are entitled to the concern and assistance of the community, expressed through public and voluntary resources. This is their right, as citizens of the United States and of California.
2. Where necessary, the State must discharge the obligation of society.
3. The best hope is prevention, and it is our responsibility to develop new knowledge through research and to apply it promptly. Meanwhile, we have an obligation to the retarded who are already with us.
4. There is some potential for growth in every human being. For each person, society should provide the opportunity to develop to the limits of his capabilities.
5. Services should be planned and provided as part of a continuum, which means that the pattern of facilities and eligibility shall be so complete as to meet the needs of each retarded person, regardless of his age or degree of handicap, and at each stage of his life development. It also means a continuity, including uniform eligibility standards, to insure that no retarded individual is lost in the transition from one service to another.
6. Because the retarded person is a human being first, and a handicapped individual secondarily, he should have access to all the general community services that he can use in common with others. Only when integrated services fail to meet his needs should there be specialized services.
7. Services for retarded persons should be close to their homes and families. This applies to state hospitals and other residential facilities as well as to diagnostic, educational, recreational and other community services. Moreover, no retarded person should enter an institution who can

be cared for in the community, and no one should remain in an institution who can adjust outside.

8. Provision for research, and for training of professional persons to work with the mentally retarded, should be built into service programs wherever appropriate and possible. Research and professional training are two essential components of the total program, and a pattern of services is incomplete without them.

9. Retarded persons, or their families acting in their behalf, should have substantial freedom of choice among public and private services. This accords with the dignity of the individual and his right of self-determination for his own life.

10. The State should provide for and encourage creative flexibility in all programs operating for the mentally retarded in California.

RECOMMENDATIONS FOR ACTION IN 1965

For immediate, first priority consideration by the Legislature, the Study Commission on Mental Retardation recommends:

Establishment of a Mental Retardation Program Board, including persons from all state departments now having responsibility for the retarded, plus representatives of local and voluntary organizations. The Board should have authority to review the budgets for present and proposed programs of service for the mentally retarded, should be responsible for developing a coordinated plan for State services, and should serve as a contractor in purchasing services for the mentally retarded.

Appropriation to the Board of \$2,000,000 for the stimulation of new services to meet the needs of the mentally retarded. This sum is in addition to funds which will be appropriated to State departments for continuance and normal growth of present programs.

(See pages 82-85)

In future years, the Mental Retardation Program Board will present recommendations to the Governor and the Legislature for program priorities and appropriations. Because the Board does not yet exist, and because it is important to start immediately to meet the needs of California's retarded citizens, the Study Commission proposes the following actions in the fiscal year 1965-66:

1. Establishment of Regional Diagnostic and Counseling Centers, located no more than two hours' driving time from any California family. The Study Commission anticipates ten or more such centers, at an average annual operating cost of \$150,000. In the first year, it would be reasonable to launch six such Centers, and the total budget for 1965-66 would not exceed \$900,000.

(See pages 46-50)

2. Development of residential facilities other than state hospitals, to serve the mentally retarded who are not sick but who need care away from their own homes. These facilities will include residential schools, foster homes, boarding homes and supervised living arrangements to meet the different needs of retarded children and adults with different degrees of handicap. Some will be under public sponsorship (local as well as State); some may

be private. Total cost to the State for the first year may be estimated at \$500,000.

(See pages 73-75)

3. Provision of rehabilitation services which will enable retarded adults to become as self-sustaining as their capabilities will allow. This program will call for cooperative efforts by the Department of Education, the local schools, the Department of Rehabilitation, the Department of Employment and other State and local agencies. At full scale, the program will cost up to \$3,065,000 a year, but because of Federal funds available on a matching basis, the State of California would have to appropriate only \$1,190,000.

(See pages 61-69)

4. Strengthening of special-education programs in the school districts and county systems, by such actions as:

a. Providing for reimbursement from the General Fund to the State School Fund up to 100% of the ceiling authorized.

b. Authorizing funds for transportation to and from work station assignments.

c. Increasing school support to finance proper class sizes for adult retarded.

d. Making it possible for county superintendents to pay living expenses for retarded children who cannot receive education in their own districts.

e. Extending school building aid to county superintendents and providing one-half the cost of all classrooms constructed for the retarded, including those in adult education.

These actions will enable local districts and county school offices to fulfill their mandate to educate the mentally retarded. It is not possible to estimate the dollar cost of these recommendations because several of them depend on the school enrolment and average daily attendance, which are impossible to predict.

(See pages 55-61)

5. Establishment of child care centers for the mentally retarded throughout California. Expanding from the present four pilot centers will require in the next year \$722,400.

(See pages 56-57)

6. Professional Training.

a. Direction to the University of California and the California State College system, to develop new programs at the graduate and undergraduate levels, for the effective training of additional professional personnel for work with the mentally retarded. Because the development of new academic and professional training programs takes time, the cost during the coming fiscal year should be minimal. It is important, however, that the Legislature declare its concern for a stepping-up of professional training efforts and assert its intention to finance such programs at the proper level.

(See pages 97-99)

b. Continuation and expansion of State grants to teachers of exceptional children, so that they may pursue advanced summer study without financial sacrifice. For the summer of 1965, a minimum appropriation should be \$150,000.

(See pages 95-96)

7. Encouragement of research that will discover causes of mental retardation and point toward prevention or amelioration. Much effective research is now under way in California's institutions of higher education, state hospitals and other public and private facilities. A great deal of it is financed by the Federal government and by private foundations. What is needed is a small-grant mechanism which will encourage good research people to be creative, and will promote continuity. Millions of dollars are available for use in making major discoveries, if the State of California will appropriate a yearly sum of \$250,000.

(See page 90)

Action on the six proposals (exclusive of #4, special education) in the year ahead will cost the State of California \$3,712,400. This is less than 4 percent of the amount now being spent annually. The new appropriation will make it possible to obtain considerably more in funds from other sources, so that each California tax dollar may buy many times its worth in services.

The new approach will open doors for better services, so that California can offer real hope to the mentally retarded and their families. Ultimately, through rehabilitation and through prevention, the State will serve its people better and will reduce the cost. Enlightened, efficient programs for the mentally retarded are sound public economy.

THE RECOMMENDATIONS, IN SUMMARY

The Study Commission's highest-priority recommendations appear on the foregoing pages. Following are all the proposals contained in the body of the report, with reference to the pages on which they appear in detail.

For the attention of the Governor
and other executive and administrative officials
the Study Commission on Mental Retardation recommends:

That the Mental Retardation Program Board, recommended elsewhere, conduct regular review of existing programs in relation to needs, reexamine present assumptions in the light of new information, and take responsibility for continuous planning. (Section XIV, pages 102-103; also page 75)

That sponsors of service programs for the retarded include provisions for research and for professional training at every opportunity. (page 52)

That every agency concerned with mental retardation establish a positive program of public information and education. (page 100)

That all service agencies develop and use a type of record-keeping which will facilitate comprehensive and continuous planning for the mentally retarded. The records should indicate actual unit costs of providing services. (page 22)

That the Department of Public Health continue and increase its efforts to raise standards of prenatal, obstetric and pediatric care at all hospitals in California, with special attention to county hospitals. (page 41) Also that the Department study the cost of a program of State subventions to county hospitals for maternal care. (page 42)

That the Department of Social Welfare include in its medical care program for families with dependent children provisions for prompt and continuous prenatal, obstetric and post-natal care. (page 42)

That the Department of Education work with the Department of Rehabilitation to obtain Federal funds to implement work experience education and occupational training programs. (page 60)

That the Department of Rehabilitation assign rehabilitation counselors to schools, when the school districts request such assistance; and that the Department encourage local training centers and sheltered workshops to work closely with the schools. (page 62)

That the Department of Employment direct its local offices to be alert for job opportunities for retarded workers; and that the local employment officers work cooperatively with rehabilitation counselors. (page 62)

That the State Personnel Board and all agencies and departments of the State utilize the specialized placement program to employ retarded persons. (page 67)

That the shortage of skilled professional personnel be met through aggressive recruitment, enlargement of training opportunities, promotion of interest in work with the retarded, expansion of in-service training programs, redefinition of tasks, financial assistance to qualified applicants, and appropriate use of volunteers. (pages 93-95)

That the recommendations of the Welfare Study Commission (January 1963) with respect to recruitment and training of social workers be put completely in effect. (page 92)

That the Coordinating Council for Higher Education review the entire report and consider how each of California's universities and colleges may make its contributions to research, professional training, adult education and community development. (Section XII)

That at each university and college, the president or chancellor consider the establishment of a faculty committee on human development, to effectuate coordination. (page 99)

For Legislative action
the Study Commission on Mental Retardation recommends:

Creation of a Mental Retardation Program Board, to serve as a contractor in purchasing services for mentally retarded persons, and to be the program review and planning arm of the State. (Principles underlying the Board concept, and a detailed explanation of how it will work, appear at pages 78-84, and in Section XIV, pages 102-103. Specific recommendations for the fiscal year immediately ahead are at pages 84-85.)

Establishment of centers for specialized and expert care of premature infants. (page 42)

Establishment of Regional Diagnostic and Counseling Centers, close to population centers and institutions of higher education and research, and augmented where necessary by traveling clinics. (pages 46-50)

Expansion of the present system of Pilot Child Care Centers for Retarded Children into a statewide system. (pages 56-57)

Provision for a total of 13,200 beds at hospitals for the retarded by 1970. This requires acquisition, through construction or otherwise, of 4,150 hospital beds. The new beds may be under a diversity of auspices, including county or municipal governmental units, local pediatric or general hospitals, and nursing homes, as well as state hospitals. The State, however, should assume responsibility for financial assistance and for setting and enforcing standards of care. Specific criteria are offered in the report. (pages 71-73 and Appendix F)

Encouragement of a variety of residential facilities to meet the diverse needs of the mentally retarded. The Commission foresees a need by 1970 for 12,000 to 20,500 beds. The State should take responsibility for setting and enforcing standards and for helping finance these services. (pages 73-75)

Establishment of a public guardianship service, available to every California family with a retarded child. (pages 76-77)

Authorization for the Juvenile Court to serve in loco parentis, irrespective of the age of the retarded person, in cases where the retarded individual and his family are unable to make appropriate decisions. (page 79)

Expansion of the Maternal and Child Health program of the Department of Public Health, to intensify services aimed at preventing mental retardation in high-risk groups. (page 41)

Authorization of a section in the Department of Public Health to mobilize public health resources for the attack on retardation. (page 41)

Authorization to the Department of Public Health to recommend testing for inborn errors of metabolism and related conditions leading to mental retardation. (page 41)

Encouragement and adequate financing of public health programs to explore genetic causes of mental retardation and other defects. (page 88)

Establishment of statewide, uniform admission policies for county hospitals. (page 42)

State subvention to county hospitals for maternal care. (page 42)

Financial assistance to school districts to locate and identify the hidden retarded children. (page 57)

Provision of authority to the county superintendent to pay tuition and other costs of educating a retarded child away from his local school district. (page 59)

Reservation of an adequate share of the reimbursement per unit of average daily attendance, to finance the special-education program. (page 59)

Financial assistance to school districts for special education of retarded adults. (page 61)

Provision of one-half the cost of classrooms constructed for the mentally retarded; and extension of school building aid to county superintendents. (page 59)

Financial assistance to provide transportation for moderately retarded youngsters between school and work station. (pages 59-60)

Authorization to provide rehabilitation service to retarded individuals at whatever age they are ready. (page 63)

Authorization for the Department of Rehabilitation to develop contracts with school districts to provide rehabilitation counselor service. (page 63)

Authorization for the Department of Rehabilitation to establish vocational rehabilitation units for service to the mentally retarded at all the Department's major offices, and to add vocational rehabilitation counselors to the state hospitals for the retarded. (pages 66-67)

Continuance and expansion of the cooperative program of the Departments of Rehabilitation and Social Welfare, offering sheltered workshop facilities to mentally retarded recipients of Aid to the Disabled. (page 64)

Amendment of the Aid to the Disabled law to make ATD a resource for all needy mentally retarded adults, including those who may benefit from group care. (page 74)

Change in language of the Aid to the Disabled law to encourage rehabilitation of the mentally retarded. (page 31)

Implementation of those recommendations of the President's Panel on Mental Retardation, with respect to recruitment and training for the professions, which are applicable at the State level. (page 91)

Enactment of the recommendations of the Welfare Study Commission pertaining to recruitment and training of social workers. (page 92)

Extension of the law appropriating funds for the Department of Education to pay summer school expenses for teachers seeking to prepare for careers in special education. (pages 60, 95)

Amendment of the Licensing of Certificated Personnel Law to encourage teachers to go into special education. (page 60)

Establishment of a Child Study Center for the Retarded, under the auspices of one or more universities or state colleges. (page 89)

Provision of adequate budgetary support of research programs in the biological and social sciences, including establishment of a small-grant mechanism. (pages 89-90)

For consideration of the U. S. Congress,
because of the impact of existing laws on California planning,
the Study Commission on Mental Retardation recommends:

Amendment of the Social Security Act to permit the payment of Federal funds to mentally retarded persons residing in private institutions. (page 85)

Amendment of the section of the Social Security Act referring to "total and permanent disability" to convey a more positive and hopeful concept of rehabilitation. (page 31)

For consideration by local public officials
the Study Commission on Mental Retardation recommends:

That each community create its own machinery for comprehensive planning on mental retardation, conforming to standards set by the Mental Retardation Program Board. (pages 51, 84)

That the community provide for the mentally retarded as it does for all its citizens; and that general community services be open to the retarded insofar as they are appropriate. (page 51)

That there be available to every family the services of a diagnostic clinic; that information and referral services be available as part of a comprehensive program of family counseling; and that there be provision for systematic follow-up and reevaluation of retarded children in their preschool and later years. (page 70; also page 53)

That service programs for retarded persons include provisions for research and professional training. (page 52)

That a positive program of public information be part of every local service program. (Section XIII)

That organizations and agencies providing community services accept responsibility for the keeping of records which will aid program planning. (page 52)

That communities assess the efforts they are making to integrate and absorb newcomers, and give thoughtful consideration to how they may help the new residents change the pattern of their lives for the better. (page 45)

That every local health department alert its staff to the importance of preventive action on mental retardation. (page 42)

That home nursing service be available under local sponsorship for families that have children with multiple handicaps. (page 52)

That agencies offering public health nurse and homemaker services train their staffs in the special aspects of home training for the retarded. (page 53)

That the county welfare department be responsible for finding, licensing and supervising foster homes and other private residential facilities for the mentally retarded. (page 74)

That high school districts review their policies and programs to improve and extend services to retarded youth at the level of secondary education. (page 58)

That school officials, rehabilitation counselors and employment specialists be in regular consultation with reference to each retarded youngster who is moving along the continuum from special education and training to employment. (page 62)

For public attention
the Study Commission on Mental Retardation observes:

Mental retardation is a social problem. That is, it concerns not only the retarded person and his family but his neighborhood, the community and all the people of California. (page 1)

Everyone can help to prevent retardation. (page 42)

There is an urgent need for trained professional and other personnel to work with the mentally retarded, and young people seeking careers might well look to this field of service. (pages 91-92 and 96)

Membership organizations can perform a service in offering personal guardianship or parent-substitute programs. (page 76)

Churches and synagogues can make special contributions to the well-being of the mentally retarded. (page 69)

FOREWORD

The California State Legislature at its 1963 session created the Study Commission on Mental Retardation and directed it to "study and make recommendations on the following:

"(a) Planning and implementation of policies, procedures, programs, services and activities pertaining to identification, care, treatment, education and general rehabilitation of mentally retarded persons and research in the field of mental retardation.

"(b) Full utilization of the services and facilities available to the State from the Federal government for the benefit of mentally retarded persons.

"(c) Statutory revisions necessary to carry out the recommendations of the commission. "

The first step toward accomplishing this assignment was to ask questions: Who are the mentally retarded in California? How many are there? What is the State now doing to help these people? What other resources are there? What do the present laws provide? The Study Commission found some of the answers, though not all.

Next came the task of formulating a program to meet the needs of the mentally retarded--a program which would be both desirable and realistic. With the help of State departments and local agencies, professional and civic organizations, and many interested citizens, this task was relatively easy.

Finally, it became necessary to consider how to make the program recommendations possible. This called for bold, creative proposals on administration and financing.

Insofar as possible, this report to the Governor and the Legislature follows in outline the three steps the Commission pursued. Some of the Commission's findings, and other supporting documents, have been published separately and are available as indicated in the body of this report.

In organizing the conclusions and recommendations, the Commission might have approached the subject in chronological terms: The Home Years, The School Years, The Adult Years. This segmental approach is not realistic, however, because an individual moves gradually from one stage to the next. The President's Panel on Mental Retardation declared the need for a continuum

of services for the mentally retarded; Governor Brown reemphasized this need in his charge to the Study Commission at its first meeting; and the Commission has accepted and endorsed the viewpoint.

The Commission might also have looked at service needs in terms of the degree of handicap of the retarded person: severely, moderately, mildly, borderline. It is not possible to classify human beings rigidly, however. Each retarded person is an individual, with unique family and other attributes which make his needs different from others' and call for different answers. The mildly retarded person may be handicapped to a considerable degree if he also has a physical disability, or if his retardation is complicated by emotional disturbance. The moderately retarded child may grow up to function quite well in the community or may require lifetime care, depending in part on the nature and quality of professional attention he receives from an early age. Even the severely retarded, many of whom need long-term residential care, may get along well in their own homes or in community foster homes for part of their lives.

The philosophy of the Study Commission encompasses the view that each mentally retarded person is an individual, different from others, yet entitled to the same respect for his dignity as a human being. The Commission also believes that programs to meet the needs of this individual-- and the hundreds of thousands of other Californians who are mentally retarded-- must be flexible and adaptable.

No one yet knows all the answers. It is the Commission's hope that in proceeding to meet the needs of California's mentally retarded and their families, we may leave all doors open for the effective use of new knowledge.

Section I.

WHO ARE THE MENTALLY RETARDED? HOW MANY ARE THERE?

To cope with a problem, one must first define it. Formulating a universally acceptable definition of mental retardation, however, is a task to rank with the twelve labors of Hercules. Recognized authorities cannot agree--and there are good reasons.

For one thing, mental retardation is a condition, or a collection of symptoms, rather than a specific disease entity. There are scores, perhaps hundreds, of causes, and many different manifestations.

Moreover, the person who is or appears to be mentally retarded in one field of human activity may be quite "normal" or indeed superior in another field. Mental retardation has different meanings in medicine, in education, and in the contemporary job market, to name only three areas among many that are important.

To develop a comprehensive plan for California's mentally retarded, the Study Commission required an operational definition, one on which there could be agreement and the possibility of thinking together, but which would be flexible enough to accommodate the different worlds the retarded individual encounters as he moves through life. The Commission accepted as a working definition the language of the American Association on Mental Deficiency (AAMD):

"Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior."¹

The President's Panel on Mental Retardation put it in more colloquial terms: "The mentally retarded are children and adults who, as a result of inadequately developed intelligence, are significantly impaired in their ability to learn and to adapt to the demands of society."²

The AAMD elaborates its definition by citing three aspects of impaired adaptive behavior: maturation, learning, and social adjustment. Each of these has special pertinence at a different stage of the individual's

1. Citations and references appear at the end of this report, under the heading "Notes."

life. Rate of maturation relates principally to the development of self-help skills in early childhood. Learning difficulties are usually most apparent during the school years. Social adjustment applies especially at the adult level, where it is a criterion of the person's ability to maintain himself in the community and meet the standards society imposes. The AAMD notes that although impairment in only one of the three is enough to confirm a diagnosis of mental retardation, in most cases retarded persons will prove deficient in all three.

At the same time, authorities note that the term mental retardation may describe an individual at only one period of his life,³ and this is a concept of major importance in the thinking of the Study Commission. In other words, a person may move in and out of the segment of the population called retarded, as greater and less demands are put upon him by society. Thus, the preschool youngster who plays at home may appear no different from other small children; at school he may fall behind his classmates and receive the label "retarded"; in his adult years, with proper training and vocational guidance, he may perform quite competently. The same individual, with the same intellectual limitations, thus shows up as retarded during only one part of his life.

Dr. George Tarjan, superintendent and medical director of Pacific State Hospital, has suggested that for practical purposes it may be appropriate to consider prevalence in terms of four sub-groups of the population: those who "obtain" retardation services; those who "seek" them; those who pose problems and therefore "need" the services; and those who could "benefit" from services but as yet neither seek nor obtain them nor pose visible problems.⁴ By this classification system, the number of retarded persons calling for immediate attention, or those representing an unmet need for service, would be far lower than indicated by the Commission.

The Study Commission recognizes that Intelligence Quotient is an imprecise index. Nevertheless, as a rough gauge of the major gradations of handicap, the Commission has also accepted the classification system proposed by the American Association on Mental Deficiency:⁵

| | | |
|-----------|---------------------|------------|
| Level I | Borderline | (IQ 70-84) |
| Level II | Mildly Retarded | (IQ 55-69) |
| Level III | Moderately Retarded | (IQ 40-54) |
| Level IV | Severely Retarded | (IQ 25-39) |
| Level V | Profoundly Retarded | (IQ 0-24) |

In planning for large numbers of retarded people, this grouping is helpful; yet it is necessary to keep in mind the warning that "the former convenient criteria of definitive degrees of intelligence need to be replaced by more dynamic and fluid criteria based on levels of performance."⁶ Level I, the borderline group with IQ up to 84, is not a useful or meaningful classification for the adult years. Moreover, persons of IQ above 80 are not eligible for placement in special public school programs for retarded pupils although they often pose problems, especially in the high school years; in the lower grades and in adulthood, however, most of them manage to get along without special help.

In estimating the number of retarded persons, therefore, different definitions and different cut-off points should be used at various stages of the individual's life. At any rate, this has been the assumption of the Study Commission, whose task has been pragmatic rather than scientific. That is, in order to plan and provide services for the mentally retarded of California, it is necessary to think of those who present problems, rather than those who may be classified as retarded on a theoretical basis.

While this approach reduces the number called retarded in their adult years, it has also the effect of increasing the totals in the age range of the school child, and even more so in the preschool years. The reason is that young children may behave as if retarded, and may require the same services of home care and early training as if they were retarded; yet some of them, as they develop, prove not to be retarded. If they were denied the special services in early childhood, however, they might continue to perform at the level of retarded children, and the need would become more apparent, not less, as they progressed through school.

The generally accepted figure on the prevalence of mental retardation is 3 percent, and as the President's Panel noted, this would mean 5,400,000 retarded children and adults in the United States.⁷ For California, on the basis of the present population of 18 million, the number of mentally retarded would be 540,000.⁸

The Study Commission has been unable to find evidence to support so large a total. Reliable information based on field studies is much needed, but in terms of the Commission's aims and criteria, it seems realistic at this time to work with an estimated total, for the mentally retarded of California, of about 400,000, or 1.86 percent of the State's population, in 1970. To repeat, the prevalence varies in the different age ranges, but the basis for the total is apparent from Table I.

While there have been several prevalence studies in the United States and elsewhere, most of them have been fragmentary, based on limited samples, and not easily comparable with one another. There is still need

TABLE I
Population of California and Estimated Prevalence of Mental Retardation

| Age | 1960 Census | Percent of Population Estimated to be Retarded** | Estimated Number of Retarded | 1970 Anticipated Population* | Percent of Population Estimated to be Retarded** | Estimated Number of Retarded |
|--------------|-------------------|--|------------------------------------|------------------------------------|--|------------------------------------|
| Under 5 | 1,746,000 | 0.5 | 8,730 | 2,150,000 | 0.5 | 10,750 |
| 5 - 7 | 992,000 | 2.2 | 21,824 | 1,235,000 | 2.2 | 27,170 |
| 8 - 16 | 2,479,000 | 3.0 | 74,370 | 3,715,000 | 3.0 | 111,450 |
| 17 - 54 | 7,530,000 | 2.0 | 150,600 | 10,717,000 | 2.0 | 214,340 |
| 55 - 59 | 706,000 | 1.5 | 10,590 | 1,000,000 | 1.5 | 15,000 |
| 60 - 69 | 1,101,000 | 1.0 | 11,010 | 1,449,000 | 1.0 | 14,490 |
| 70 plus | 863,000 | 0.5 | 4,315 | 1,196,000 | 0.5 | 5,980 |
| TOTAL | 15,417,000 | 1.83 | 281,439 | 21,462,000 | 1.86 | 399,180 |

* Based on projection of California Department of Finance, 1963 (civilian only).

** The percentages have been estimated by the Commission on the basis of information collected from a variety of authoritative sources.

for comprehensive information on the prevalence and levels of mental retardation. Some authorities believe, on the basis of statistical reports of the U. S. Selective Service, that the prevalence of mental retardation is lower in California than the average for the nation. It is hoped that the study of the city of Riverside, California, conducted in 1963 and now being compiled, will disclose more precise and usable information than has heretofore been available.

Meanwhile, on the basis of studies already published, the Commission notes the following generalizations which relate to definition and prevalence of retardation:⁹

1. As many as 80 percent of the individuals diagnosed as retarded by a simple criterion such as IQ score may be found to be nonretarded if several criteria are used.
2. The prevalence of mental retardation appears to be different for different racial groups in the population (at least according to a study in Delaware), but it is probable that this reflects socio-economic differences.
3. Low income and poor housing populations have a disproportionately heavy retardation rate.
4. The retarded are to be found in significantly high numbers among the unemployed and part-time workers.

Fragmentary statistical information now available suggests a significant difference in prevalence of retardation in relation to socio-economic levels. Some types of retardation appear to occur at random, but others seem to be linked with economic level or cultural status. The Study Commission conducted an examination of records in the Los Angeles City Schools and discovered a marked differential among the student population, with those children in the lower socio-economic groups having a higher prevalence of mental retardation. (See Table II.)

All available evidence makes it seem reasonable for the Commission to use different measurement standards for different programs in trying to estimate the number of individuals needing services and the cost that providing these services would entail. Acknowledging the limitations of past studies and present statistical methods, and on the basis of information now in hand, the Commission believes that Table I represents the most nearly reliable data on the mentally retarded population of California.

At a minimum, it is clear that by 1970, more than ten thousand children under 5 years of age will require special health and welfare services

to prevent or ameliorate their retardation. Almost 154 thousand children and youth between the ages of 5 and 18 will require special instruction in public or private educational institutions. Indications are that, even with the extension of preventive services, more children will be born with multiple handicaps, aggravating the severity of their condition. In the age group which makes up the work force (age range 19 to 64), the predicted presence of more than 222 thousand suggests a social and economic dimension of major significance.

If, as some have suggested, the Commission's figures are too low, we believe that they are a workable measure of the huge task ahead for the State and the communities of California. When we have planned adequately and have actually provided services for these mentally retarded persons--approximately one out of every 50 Californians--there will be time to measure again the unmet need.

TABLE II

Prevalence of Mental Retardation as Compared
with Socio-Economic Level of the Community
(Based on a Study in Los Angeles)

| SCHOOLS | Socio-Economic Levels | | |
|--------------------|-----------------------|--------|------|
| | LOW | MIDDLE | HIGH |
| Elementary School | 10.8% | 5.1% | 0.4% |
| Junior High School | 6.8% | 2.6% | 1.1% |
| Senior High School | 4.4% | 2.4% | 1.3% |

Section II.

WHAT IS CALIFORNIA DOING NOW ?

To point a direction, it is necessary to know where one is. In order to develop a comprehensive plan for mental retardation, as directed by the Legislature, the Study Commission started by examining existing services. Through its Committee on Existing Resources, Functions, and Coverage, with staff assistance from a consultant retained for the purpose, the Commission sought to discover the scope and nature of present services offered by departments of State government and by public and voluntary agencies in selected counties. The survey took three months, and yet, as noted in the report,¹⁰ the speed of the schedule imposed a severe limitation in securing information. The factual findings are neither complete nor totally reliable, despite conscientious efforts, within the time available, to verify all information.

Nevertheless, the facts garnered and assembled by the committee are revealing. They disclose services to the mentally retarded by agencies not normally considered to be working in this field; expenditures considerably larger than previously recognized; unevenness of programs as among communities, and even within single counties. The report points up gaps in service, and it emphasizes that even where a program exists it does not necessarily serve everyone who needs it. Finally, the survey revealed that some information is simply not available; some agencies that are serving considerable numbers of retarded persons were unable to report precisely on the volume of service or the amount of money expended. The Study Commission makes no criticism of existing agencies in this regard, but it is obvious that there must be a different type of record-keeping if comprehensive and continuous planning is to be meaningful.

Services Offered by State Departments

Table III,¹¹ pages 24-26, provides a survey of the type of services being offered to the mentally retarded by each of seven departments of California State government. Marked with the "xx" are those services which the departments indicate they are best prepared to offer. It is well to note that such a checking type of tabulation does not indicate the completeness of services offered nor the depth or efficiency of the service. Other than a few instances where numbers are shown for a particular service, this table does not show the extent of the services provided either numerically or geographically. The pages do show the purpose, planning and activity of the departments

A brief analysis of Table III gives rise to the following observations, among others:

1. Services toward prevention rest largely within the Departments of Mental Hygiene and Public Health.

2. There is a sparsity of service offered in the areas of home training, nursery schools and day care centers for the mentally retarded, and in only one instance is one counted as a major service--the Pilot Child Care Centers for the Mentally Retarded under the administration of the Department of Education.

3. Adult education programs show very little emphasis.

4. Other than in the state hospitals, vocational rehabilitation appears largely in the Department of Rehabilitation, with a new development indicated in the contract between the Departments of Rehabilitation and Social Welfare.

5. Day and residential care and life services would naturally be found in those agencies with legal assignments in those areas. It is surprising to note, however, the contrast in emphasis on recreational services between the hospitals for the mentally retarded on one hand, and other departments such as Education which might be expected to place more emphasis on recreation than was reported.

6. Heavy checking in research, training, case finding, referral and public education indicates concern by many agencies in the problems of the mentally retarded. The only check for religious services appears in the institutional setting of the hospitals.

Following are the amplifications of abbreviations used on pages 24-26 in order:

Hospitals for Mentally Retarded
Bureau of Social Work
Outpatient Psychiatric Service
Evaluation and Referral Service
State Education Office
District Classes for Mentally Retarded
State Schools for Cerebral Palsied
District Classes for Orthopedically
Handicapped

State School Building Aid
Pilot Child Care Centers
Department of Employment
Department of Public Health,
including local health departments
Department of Rehabilitation
Department of Social Welfare
Department of Youth Authority

TABLE III

Type of Services for the Mentally Retarded Being Offered by California State Departments
 Services Each Department is Best Prepared to Offer are Indicated by Double X
 Numbers Indicate the Number of Clients Involved When Noted on Returned Questionnaires

| | <u>Dept. of Mental Hygiene</u> | | | | <u>Dept. of Education</u> | | | | | | | | | | |
|-------------------------------|--------------------------------|----------------|---------------|----------------|---------------------------|----------------|---------------|---------------|----------------|------------|---------------|------------------------------|-------------|------------------|-------------------|
| | M.R. Hosp | Bur. Soc. Work | Out-Pat. Psy. | Eval. & Refer. | State Office | Dis-trict M.R. | St. C.P. Sch. | Dis-trict OPH | Sch. Bldg. Aid | Child Care | Dept. of Emp. | Dept. Pub. Hlth. State Local | Dept. Rehab | Dept. Soc. Welf. | Dept. Youth Auth. |
| <u>Health Services</u> | | | | | | | | | | | | | | XX | XX |
| Prevention | XX | | | | | | | | | | | XX | | | X |
| Med. Diagnosis | XX | | X | XX | | | X | | | | | X | X | X | X |
| Med. Treatment Medication | XX | | X | X | | | X | | | | | X | X | X | X |
| Med. Counseling-Client | XX | | X | XX | | | X | | | | | X | X | | X |
| Med. Counseling-Parent | XX | | X | XX | | | X | | | | | X | | | |
| Visiting Nurse | X | | | | | | | | | | | X | | X | |
| Nursing Care | XX | | | | | | X | | | | | X | X | | X |
| Other: | | | | | | | | | | | | | | | |
| Consultnt-Comm. Agcy. | | | X | | | | | | | | | (1) | | | |
| Dental & Psychiatric | | | | | | | | | | | | | | | X |
| Podiatrics | X | | | | | | | | | | | | | | |
| <u>Psychological Services</u> | | | | | | | | | | | | | | | XX |
| Diagnosis | XX | | X | XX | | XX | XX | X | | X | | XX | X | | X |
| Counselng & Thrpy-Parent | XX | | | XX | | | XX | | | X | | X | | | |
| Counselng & Thrpy-Client | XX | | | XX | | | XX | | | | | X | X | | X |
| <u>Educational Services</u> | | | | | | | | | | | | | | | |
| Home Training | X | | | | | | | | | | | | | | |
| Nursery School | X | | | | | | | | | X | | | | | |
| Day Care Centers | | | | | | | X | | | XX | | | | | |
| Special Classes: | | | | | | | XX | | | | | | | | |
| *EMR | XX | | | | | | 48,388 | | | | | | | | X |
| **IMR | XX | | | | | | 24,207 | | | | | | | | |
| Other | X | | | | | | | X | XX | | | | | | |
| State-Wide Supervision | | | | | | | | | | | | | | | |
| Coord. Education of M.R. | | | | | XX | | | | | | | | | | |
| <u>Adult Education</u> | | | | | | | | | | | | | | | |
| Special Program | X | | | X | | | | | | | | | | | |
| Regular Program | X | | | | | | | | | | | | | | |
| Other | X | | | | | | | | | | | | | | |

*Approx. 50-75 IQ
 **Approx. 30-49 IQ
 Note: Licensing of Private Institutions and Short-Doyle shown in the committee report, Table XV.
 (1) Other services listed on page 30.

TABLE III (Continued)

Type of Services for the Mentally Retarded Being Offered by California State Departments
 Services Each Department is Best Prepared to Offer are Indicated by Double X
 Numbers Indicate the Number of Clients Involved When Noted on Returned Questionnaires

| | Dept. of Mental Hygiene | | | | Dept. of Education | | | | | | | | | | |
|--|-------------------------|----------------|---------------|----------------|--------------------|-----------------|---------------|----------------|----------------|------------|---------------|------------------|--------------|------------------|-------------------|
| | M.R. Hosp. | Bur. Soc. Work | Out-Pat. Psy. | Eval. & Refer. | State Office | Dis- trict M.R. | St. C.P. Sch. | Dis- trict OPH | Sch. Bldg. Aid | Child Care | Dept. of Emp. | Dept. Pub. Hlth. | Dept. Rehab. | Dept. Soc. Welf. | Dept. Youth Auth. |
| Vocational Habilitation & Placement Services | | | | | | | | | | | | State and Local | | | XX |
| *Sheltered Workshop-EMR | XX | | | | | | | | | | | | X | XX 200 | |
| **Sheltered Workshop-TMR | XX | | | | | | | | | X | | | | | |
| Employment Service | | | | | | | | | | | X | | XX | | X |
| Supervision | | | | | | | | | | | | | X | | X |
| Voc. Counseling-Client | | | | X | | | | | | | X | | XX | | X |
| Voc. Counseling-Parent | | | | X | | | | | | | X | | XX | | |
| Voc. Trng. Reg. Sch. | | | | | | | | | | | | | X | | X |
| Voc. Training Center | X | | | | | | | | | | | | XX | | |
| Work Experience Prog. | XX | | | | | X | | | | | X | | XX | | |
| Occup. Day Care Center | | | | | | X | | | | | | | | | |
| Work Placement | | XX | | | | | | | | | | | | | |
| Occup. Training Prog. | | | | | | XX | | | | | | | | | |
| Aptitude Testing | | | | | | | | | | | X | | | | |
| <u>Social Services</u> | | | | | | | | | | | | | | | |
| Social Welfare | X | | | X | | | | | | | | | | | X |
| Financial Aid | X | | | | | | | | | | | | X | XX | |
| OASI | X | | | | | | | | | | | | X | | |
| Social Adjust. Centers | | | | | | | | | | | | | | | |
| Consultation, Comm. Agcy | | | | | | | | | | | | | | | |
| Transportation | | | | | | | | | | | | | X | | |
| Mother's Helper | | | | | | | | | | | | | | | X |
| Home Econ. Visitation | | | | | | | | | | | | | | | |
| Homemaking Consltnt | | | | | | | | | | | | | | | |
| Attendant Care | | | | | | | | | | | | | | | XX |
| Family Service | | | | | | | | | | | | | | | X |
| Other: | | | | | | | | | | | | | | | |
| Comm. Organization | | XX | X | | | | | | | | | X | | | |
| Consltnt, Outside Agcy | | X | X | | | | | | | | | X | | | |
| Casework Service to M.R. & Families | X | XX | X | | | | | | | | | X | | XX | |

* Approximately 50-75 IQ

** Approximately 30-49 IQ

TABLE III (Continued)

Type of Services for the Mentally Retarded Being Offered by California State Departments
 Services Each Department is Best Prepared to Offer are Indicated by Double X
 Numbers Indicate the Number of Clients Involved When Noted on Returned Questionnaires

| | Dept. of Mental Hygiene | | | | Dept. of Education | | | | | | | | | | |
|--------------------------------------|-------------------------|----------------|---------------|----------------|--------------------|----------------|---------------|---------------|----------------|------------|---------------|------------------|--------------|------------------|-------------------|
| | M.R. Hosp. | Bur. Soc. Work | Out-Pat. Psy. | Eval. & Refer. | State Office | Dis-trict M.R. | St. C.P. Sch. | Dis-trict OPH | Sch. Bldg. Aid | Child Care | Dept. of Emp. | Dept. Pub. Hlth. | Dept. Rehab. | Dept. Soc. Welf. | Dept. Youth Auth. |
| <u>Day, Residential Care Ctrs.</u> | | | | | | | | | | | | State and Local | | | |
| Custodial Day Care | X | | | | | | XX | | | | | | | | |
| Short Term Res. Care | X | | | | | | XX | | | | | | | | |
| Foster Home Care | XX | 1453 | | | | | | | | | | | | X | X |
| Group Care Homes | X | | | | | | | | | | | | | | |
| Boarding Home Care | X | X | | | | | | | | | | | | X | |
| Halfway House Care | X | X | | | | | | | | | | | | | |
| Institutional Care | XX | | | | | | X | | | | | | | | X |
| Resid. Placem't Serv. | X | | | | | | | | | | | | | | |
| Counseling Foster Home Parents | X | X | | X | | | | | | | | | | X | X |
| <u>Recreational Services</u> | | | | | | | | | | | | | | | |
| Special Day Programs | X | | | | | X | X | | | | | | | | |
| Spec. Camping Programs | XX | | | | | | | | | | | | | | |
| Included in Reg. Prog. | XX | | | | | | | | | X | | | | | X |
| Social & Recreational Group Programs | | XX | | | | | | | | | | | | | |
| <u>Life Services</u> | | | | | | | | | | | | | | | |
| Continued Supervision and Guidance | XX | | | X | | | | | | | | | | | |
| Legal Guardianship | XX | | | | | | | | | | | | | XX | |
| Legal Assistance | XX | | | | | | | | | | | | | | |
| Research | XX | X | | X | XX | X | | | | | | XX | X | | |
| Training of Personnel | XX | X | | XX | X | X | X | | | | | X | X | X | |
| Case Finding & Referral | XX | | | XX | | XX | | | | X | | X | X | | |
| Public Education | XX | X | | XX | XX | X | X | | | | | XX | X | | |
| Coord. Federal Program | | | | | XX | | | | | | | X | | | |
| Financial Assistance to Districts | | | | | | | | | X | | | | | | |
| Religious Services | X | | | | | | | | | | | | | | |

Reliable estimates place the population of California in round figures at 18,000,000. Statistics for the State departments indicate service given to 81,303 individuals identified as mentally retarded. This is 0.4 percent of the total population. The adequacy of this service can be determined by whatever percent of incidence is used--whether the 3 percent suggested by the President's Panel or some smaller figure accepted by other responsible studies.

The total school population, kindergarten to grade 12, including those found in special State supported schools in which there is a significant number of retarded, and the classes in the state hospitals, is shown as 3,839,691. Of this total, 1.4 percent are in special classes for the mentally retarded. This, of course, includes no private school enrolment.

It is apparent that the agencies dealing with children are those showing the greatest expenditures for the largest number of retarded clients. This is particularly true with the Departments of Mental Hygiene and Education but also with the Bureau of Crippled Children Services of the Department of Public Health. In the area of service to the adult retarded, the Department of Social Welfare, offering service to meet living expenses, ranks first. This emphasis upon service to children agrees with the general knowledge that the mentally retarded individual is less apparent in adult society. Whether it is the individual who is not apparent, or whether it is the service to meet his needs that is not apparent, is as yet an unanswered question. It may be that a characteristic of a wholesome society is that the mentally retarded becomes more and more a part of the stream of normal living. On the other hand, it might be possible that such loss of identification is due to the fact that no specific services are available to which the mentally retarded can turn for help.

It is encouraging to note the development in cooperative services for the retarded in which agencies jointly provide a type of service not possible alone. Cases in point are the contract between the Departments of Social Welfare and Rehabilitation, and the opportunity now available to the Department of Employment to assign unemployed mentally retarded clients to work training in lieu of employment availability in order to qualify for benefits.

Additional details of departmental programs, as reported to the committee, include the following:

Department of Mental Hygiene: A summarization of the 17,535 mentally retarded persons on the records of the Department facilities is as follows:

12,648 were in state hospitals for the mentally retarded,
(2,223 were in special classes for the retarded either within or
outside the state hospitals),
2,555 were patients outside the state hospital setting,
1,806 were on the waiting list, and
526 were applicants not yet interviewed.

The average waiting time for admission to state hospitals is about two years. Causes of the waiting period include the rapid population increase in California, the lack of hospital facilities to meet the demands, as well as the lack of sufficient alternate facilities for caring for the retarded such as foster homes, short-term hospital and day care programs.

The Bureau of Social Work reported 2,267 mentally retarded patients on leave from the hospital as of October 1963. A recent departmental study of those on aftercare status, which includes patients on leave, disclosed that 25 percent attend special classes for the retarded in public and private schools. By applying these data to the October leave figure of 2,267, an estimated 567 patients were attending special classes. The Bureau reported 1,327 placements of patients on leave from the hospitals from November 1962 to October 1963. Of these leave placements, 344 were to home leave, 939 to family care and 44 to work placement. In spite of the increase in the number of patients on indefinite leave from the hospitals, beds are unavailable to meet the demand.

Department of Education and Public Schools: The State office expends approximately 1.1 percent of its budget for services to the retarded, largely in salary and expenses of the three full-time workers and prorated administration in the field of the mentally retarded.

During the 1962-63 school year school districts and county superintendents of schools expended over \$39,000,000 in operating special schools and classes for educable and trainable mentally retarded minors, and employed 3,898 teachers. In addition, to diagnose, refer and provide continuous evaluation for these pupils, there are many psychologists, speech therapists, nurses, physicians, and other administrative and supervisory personnel involved in the hundreds of districts and county offices maintaining these classes.

The financial outlay for current expenses is met in part by the provision of State apportionments to districts and county offices for expenditures exceeding the average costs for normal pupils and to the extent of \$375 per average daily attendance for the "educable" retarded and \$670 plus \$475 transportation for the "trainable" retarded. More than 200 districts set override tax rates from 0.0038 to 0.8066 to meet the costs. Of the more than \$39,000,000 expended by school districts and county school offices, approximately \$20,000,000 was considered excess expense. Of this latter amount the State made reimbursements of about \$13,000,000.

Two residential schools operated by the Department of Education for the cerebral palsied expend slightly more than a half-million dollars for the 60 percent of their children who are identified as retarded. The 77 districts operating classes for the orthopedically handicapped find about 26 percent of retarded children in their enrolment with a prorated expenditure of \$1,892,036. Pilot Child Care Centers for mentally retarded in Stockton, Oakland, San Jose and Seaside (Monterey County) have additional expenditures.

An estimate by the Department of Education indicates that about 63 percent of the potential educable retarded and 45 percent of the trainable were in public school classes during the 1963-64 school year. To reach the ultimate in enrolment would require at least 2,200 new classrooms and teachers, with the matching local and State funds to support the augmented program. The public schools report an acute shortage of teachers and classroom facilities as well as adequately trained administrative and supervisory personnel.

An indication of the shortage of classes and teachers is provided in a survey by the Department of Education showing that 88 classes for the trainable retarded were on double session in the school year 1963-64. This is a 25 percent increase over the previous year and 142 percent increase over 1960-61.

Department of Employment: Mentally retarded applicants are provided the same service offered to others, as there is a reluctance to determine that a person is mentally retarded in the absence of a definite medical or psychological diagnosis. Therefore, unless an applicant is formally referred by Department of Rehabilitation, Department of Mental Hygiene, or from a school, the identification is largely a matter of subjective judgment. In such referrals, or if the client is obviously retarded, he is referred to a counselor who may enlist the help of other agencies in meeting the need. The counselors work closely with Goodwill Industries, Epihab and similar organizations.

A provision in the Federal Manpower Development and Training Act makes it possible to refer "unemployable" persons to retraining programs. This should make it possible to refer potentially employable mental retardates for training in lieu of having benefits dependent upon employment availability.

Another service of the Department of Employment, through its local offices, is the training of high school youths as baby sitters for handicapped children, including the mentally retarded.

Department of Public Health: Beyond the information given in Table III, the following services are provided by State and local public health agencies: laboratory work, public health nursing, medical consultation, health education, medical social work, nutrition, epidemiologic surveillance, consultation with State and community agencies, dental and psychiatric service, occupational therapy, physical therapy, medical standards, public beneficiaries, and medical facilities and licensure.

The most easily identifiable direct service to the retarded is that of the Bureau of Crippled Children Services to the cerebral palsied. Some 7,000 such handicapped children receive care each year in this program. About half of them suffer some degree of mental retardation.

Department of Rehabilitation: In support of services to the mentally retarded, the Department spends 3.1 percent of its funds, with four staff members serving full time in this area, and the entire staff giving incidental service. A total of 761 mentally retarded clients, 16 years of age or over, were being offered the services of this agency in October 1963, over 3.7 percent of the total caseload. Services provided were in the area of vocational rehabilitation and placement--primarily in vocational advisement and evaluation, vocational training, work experience programs and job placement.

In this regard, however, the Department's report to the Committee shows only a portion of the service provided by this agency which results in a benefit to the mentally retarded. Published statements give as the responsibilities of the Department through the field counselors: establishing working relationships with handicapped clients; counseling toward overcoming the handicap; arranging for training, medical treatment, etc.; helping the client to secure work; and follow-up procedures.

Much of this service is accomplished through the encouragement of workshops. Advisory service and the employment of skilled workers to help community groups interested in establishing new workshops or improving existing facilities are provided by the Department. A significant development is the growth in the number of workshops specifically for the mentally retarded, from six in 1957 to 33 in 1963. Out of 79 workshops throughout the State, 59 have reported a total of 1,333 mentally retarded in their programs for 1962. Of this number, 753 were in 27 workshops for the retarded. The Department feels that 75 percent of the pupils in special classes for the mentally retarded could benefit from vocational rehabilitation experience and thus become productive workers.

The Department also approves grants under Public Law 565 and aids other agencies and organizations in planning and development of research projects concerning the mentally retarded such as the current ones in San Francisco (Aid Retarded Children) and in San Jose (Hope for Retarded Children).

A recent important development is the contract between the Department of Social Welfare and the Department of Rehabilitation whereby the latter provides vocational evaluation and work training services for mentally retarded recipients of Aid to the Disabled (ATD). Funds under Public Law 87-543 (H. R. 10606) are now available for some 200 persons.

Department of Social Welfare: For Aid to Families with Dependent Children (AFDC), eligibility is established for children under 18 years of age, where the family income or resources are insufficient to meet the child's needs. New regulations add unemployment as a basis for eligibility. Certain other factors of residency and property apply, but the intent is to make sure that children have the basic needs of life, and this includes an unknown number of retarded children--perhaps the usual population incidence.

Personnel of the Department advise cautious use of the incidence figure for clients in the AFDC program because it was derived from a relatively small, though official, sampling; the use of a degree of non-professional opinion; and the selection factors operating to produce the AFDC caseload.

The Aid to the Disabled (ATD) program is for those over 18 years of age who have permanent physical or mental impairment which is a major handicap, which will probably continue through lifetime, that prevents the person from doing gainful work within his competence, and is severe enough that help or supervision by another person is needed regularly to carry on the daily regimen.

The Study Commission notes with regret, however, that both the Federal and State laws establishing the ATD program contain language which suggests an insuperable handicap in the retarded person who qualifies for public assistance. The Federal law (Social Security Act, Title XIV, Section 1401) refers to "total and permanent disability." The State law (Section 4000, Welfare and Institutions Code) defines total disability to mean that "the impairment substantially precludes the individual from engaging in useful occupations within his competence such as holding a job or home-making." It is clear from the history of this and other legislation that the intent of both the Federal and State governments has been to recognize the potential of retarded persons and to encourage their rehabilitation. The Commission recommends, therefore, that the Congress and the Legislature amend the laws cited to bring the language into conformity with the intent.

The Department of Social Welfare is making an intensive effort to cooperate with the Department of Mental Hygiene in developing facilities for the care of mentally retarded adults released from state hospitals, with care for 500 such persons planned for 1964-65.

Department of Youth Authority: The percentage of funds or staff time devoted to the mentally retarded is not known, but the 2,933 youth who were identified as mentally retarded represent 16.5 percent of the entire caseload of 17,776. Applying this percentage to the total agency budget and staffing, we may infer an expenditure of close to \$4,000,000 for the retarded part of the caseload, and the equivalent of more than 100 full-time professional staff.

Identification of the mentally retarded is regarded by the Department with some reservation inasmuch as the instrument used for determining the retardation was the non-language form of a group-type test, the California Test of Mental Maturity. Individual intelligence tests usually show a smaller percent of those in the retarded area than do group tests.

It is safe to say that 2,933 persons with problems indicating mental retardation or slow learning rate are recognized and service provided by the Youth Authority.

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Following are the types of problems listed by California State departments as being most acute in serving the mentally retarded:

In Personnel

- Shortage of teachers (Ed, MH)
- Shortage of administrative and supervisory personnel with adequate training (Ed, MH)
- Inadequately trained teachers (Ed)
- Work load too heavy to permit most effective type of direct service (MH)
- Inability to fill professional staff needs under present salary schedules (MH)
- Lack of funds for staffing (SW)
- Lack of sufficient fully trained social workers (SW)
- Lack of enough vocational rehabilitation counselors (VR)
- Shortage in nursing staff (MH)
- Rapid staff turnover, particularly in nursing (MH)
- Shortage of public health physicians, nurses, therapists, microbiologists (PH)

In Housing and Facilities

- Inadequate and/or inappropriate housing for classes (ED)
- Lack of recreational facilities (MH)
- Inadequate physical facilities for small group approach (MH)

In Services

- Difficulty of offering service in sparsely settled areas (Ed)
- Double session classes for trainable retarded (Ed)
- Lack of community-based health services (Ed)
- Lack of funds for nursing home care (SW)
- Financial limitation on casework service (VR)
- Lack of appropriate day and residential placement facilities (MH)
- Lack of psychiatric facilities to treat the emotionally disturbed mentally retarded (MH)

In Programs and Practice

- Absence of tested practice and procedures for trainable retarded (Ed)

In Inter-Agency Relationships

- Lack of response of autonomous agencies to the needs of fellow agencies (MH)
- Problems of exchange of information on individual cases (MH)
- Lack of knowledge and clarification of agencies' policies, procedures, responsibilities (MH, VR)

In Public Relations

- Lack of effective programs of parent education (Ed)
- Lack of public understanding and support for sufficient financial base in connection with child care in families receiving public assistance (SW)
- Community expectation for the agency to fill the gaps in existing services (MH)

In Finance

Financial burden on parents (Ed child care centers)
 Resistance of counties to paying increased costs for
 released patients placed in other counties (MH)
 Financial burden in smaller counties close to state
 hospitals (MH)
 No program of financial assistance to those not
 eligible for public assistance (MH)
 Insufficient funds for case service (VR)
 Lack of funds for adequate specialized personnel,
 operation, and capital outlay (Ed child care centers)

Abbreviations used:

Ed, Education
 Emp, Employment
 MH, Mental Hygiene
 PH, Public Health
 SW, Social Welfare
 VR, Rehabilitation
 YA, Youth Authority

Table IV¹² is a composite presentation of funds expended and personnel involved in service to the mentally retarded as reported by seven departments of State government.

The largest expenditure is reported by the Department of Education. This financial outlay of \$43,478,738 is 2.39 percent of the entire outlay for public schools, grades kindergarten to 12, the State education office, expenditures for the State-administered schools for cerebral palsy, and the pilot child care centers. It also includes expenditures made by the county school offices. This provides 3,563 full-time teachers, prorated support for administrative and specialized personnel, and other costs of maintaining classes.

The second largest expenditure for the mentally retarded is by the Department of Mental Hygiene. More than a fourth of the expenditures of this department go for service to the mentally retarded, predominantly in the hospitals for the mentally retarded. This figure includes allied services in the Bureau of Social Work, Outpatient Psychiatric Service, Evaluation and Referral Units and prorated administrative costs. This department has the greatest number of staff involved, many of whom are employed in the hospital settings.

TABLE IV
Funds Expended, Source of Funds, and Personnel Involved
COMPOSITE FOR STATE DEPARTMENTS

| | Mental Hygiene | Education | Employment | Public Health | Voc. Rehab. | Social Welfare | Youth Authority |
|--|-------------------------|--|---------------------|-------------------------|----------------------|---------------------------|--------------------|
| Date Reporting Period | year ending 6/30/63 | October, 1963 | 1962-63 | State, Local 1962-63 | 1962-63 | 1962-63 | 1962-63 |
| Total Agcy. Yearly Budget or Expend. | \$155,014,200 | \$1,821,962,804 ¹ | \$58,672,695 | \$68,688,138 | \$6,911,558 | \$719,915,386 | \$23,249,025 |
| Per Cent of Funds: | (Excluding Short-Doyle) | (These funds are current expenses and do not include Sch.Bldg.Aid) | | | | | |
| State Taxes | | | | | | | |
| Local Taxes | | | | | | | |
| Federal Funds | | | | | | | |
| Private Funds | | | | | | | |
| Fees | | | | | | | |
| Spent for Mentally Ret. Actual & Estimated | \$ 41,526,400 | \$ 43,478,738 | (Est.) \$ 20,000 | (Est.) \$ 1,200,000 | (Est.) \$ 216,677 | \$ 4,191,700 ³ | N/A |
| Per Cent for M.R. | 26.8% | 2.39% | 3/100% | 1.7% | 3-1/10% | N/A | N/A |
| Total Professional Staff of Agency | 16,487 | 157,030 | N/A | 4,500 | | N/A | (Approx.) 3,000 |
| Serving M.R.-Full Time | 4,758 | 3,563 | N/A | | 4 | | |
| Serving M.R.-Part Time | 548 | | N/A | | | | |
| Incidental Service | | Many | Entire Staff | 4,500 ² | 252 | | 714 ⁴ |

Est.=Estimate
N/A=Not Available

¹An approximate figure, avoiding duplications.
²Except for Cerebral Palsy Program all services to mentally retarded are integrated in total agency program.

³Aid to the "Disabled" only.
⁴This is the staff which offers direct service to wards in institutions and on parole.

More than four million dollars annually is expended in Aid to the Disabled who have been identified by the Department of Social Welfare. Recipients of other types of aid where the retarded are not easily identified would add materially to this figure.

The estimated \$1,200,000 annual expenditure by the Department of Public Health includes the service to the cerebral palsied and other community and statewide programs of prevention, early identification, treatment, and research in the area of mental retardation.

Estimated expenditures by the Departments of Employment and Rehabilitation add a quarter of a million dollars more.

All told, \$90,633,515 has been identified as expended by these departments of State government on behalf of the mentally retarded. With one department unable to estimate the expenditure, and some services difficult to identify, this must be considered a minimum figure. These figures include only State governmental departments and do not reflect expenditures by private and purely local agencies.

Services Offered by and within Counties

Because of time limitations, the Study Commission was able to obtain information about local services from only a few counties. While it is true that these contain the large majority of California's population, they are not representative of local services throughout the State. The reason is that the counties were not selected as representative, but rather because they contained organizations and individuals who were able and willing to cooperate on short notice with the committee's request. Thus, for the most part, the counties are those with relatively well organized services and a fairly high degree of sophistication. Moreover, the information was gathered in diverse ways, and hence is not strictly comparable. In fact, for the most populous county, Los Angeles, the committee decided to avoid duplicating a self-study already under way, under the auspices of the Mental Retardation Joint Agencies Project, and this body of information did not become available until late in 1964, months after the committee's report was published.

The counties from which information was obtained include: Alameda, Del Norte, Fresno, Los Angeles, Orange, Riverside, San Francisco, San Joaquin, Santa Barbara, Santa Clara, Shasta and Siskiyou. Community self-studies were also under way during 1964 in San Bernardino and San Diego Counties, among others.

It is possible to offer several generalizations which apply to most of the participating counties:

A heavy emphasis upon services in the field of health, with many indications of service toward prevention. This is noted in all three areas--public agencies, private agencies and public schools.

Psychological services in diagnosis and counseling are given strong emphasis.

Educational services are given much prominence in private agencies and public schools. Public schools provide the greatest service in terms of numbers.

Adult education finds little emphasis.

Public agencies show an emphasis in vocational habilitation and placement services, indicating the influence of the work in vocational rehabilitation. Public schools in two or three counties and private agencies in six or seven counties offer services in this area. When the number of clients involved is considered, the service rendered seems inadequate.

Figures for the public schools show them to be by far the greatest service agency for the mentally retarded in the counties, either large or small. In certain small counties they appear to be the only agency, although we must assume that State departments are offering their services to the extent which the limited population allows. The extent to which the public schools are providing special education for retarded children, varies considerably--from less than one percent to almost two percent of the school-age population.

One important aspect of the service of the private organizations on the local level is recreational and social services. It is here that a call is made for much volunteer service and where funds for adequate staffing, facilities, equipment and transportation are reported as lacking. In some instances, public recreation departments and scout organizations fit into the picture. In all too many instances, local volunteer groups are struggling with a heavy load with too little financial support. This is a place where community organization specialists of the Department of Mental Hygiene and their locally organized coordinating groups are finding an open opportunity for service not otherwise provided.

Certain problems in serving the mentally retarded at the local level seem to predominate:

Lack of coordination between agencies and services and a coordinative body to pull together and organize services for the mentally retarded.

Lack of sufficient funds to employ sufficient specialized personnel.

Lack of opportunities for vocational training, work experience, sheltered workshops.

Lack of services and employment opportunities for adult mentally retarded.

Difficulty of providing transportation for retardates in outlying areas to services provided in urban centers.

Burden on parents of retarded in paying necessary fees for service by private agencies.

Lack of day care or custodial situations for short-time care.

Lack of opportunities for counseling and other supportive service for parents.

Lack of post-school service for the retarded.

Inadequate acceptance by the community and by employers of the needs of the retarded and necessary programs to meet them.

And--ever and always--shortage of funds.

Services Offered by Voluntary Agencies

The membership association and the voluntary health or welfare agency have major contributions to make. The committee queried a number of statewide and local organizations, including private institutions, schools and workshops.

The most extensive of the private agencies are the units of the California Council for Retarded Children, which sponsor local services, including parent counseling, day care centers, preschool classes and sheltered workshops. The committee concluded that this group, with a large membership of parents of the mentally retarded, is probably the chief agency providing social and recreational services to the retarded.

Other organizations providing a significant measure of service to retarded individuals include the Society for Crippled Children and Adults (Easter Seal Society), United Cerebral Palsy and several units of Goodwill Industries.

Problems in serving the retarded expressed by some of the private agencies are:

The inability to compete with public agencies in salaries to attract and keep well trained staffs.

Lack of finances to provide space and facilities for training programs, work stations, etc.

Past inexperience in working with retarded by agencies not specifically organized for that purpose.

Insufficient services of counseling, speech therapy, physical therapy.

Inadequate funds for providing transportation.

Inadequate number of staff members to deal with numbers of children.

Too few services for multiply-handicapped adults.

Section III.

THE NEED BEGINS BEFORE BIRTH

The best hope for dealing with mental retardation is prevention.

Important as it is for the State of California and its communities to provide for the mentally retarded who are already here, the effective way to handle this huge social problem in the long run is to get at the causes.

Less than a generation ago, retarded and grossly handicapped children were expected to die in infancy or early childhood--and many of them did. Today, with the advances in medical and pharmaceutical knowledge, these children approach a normal life expectancy. Moreover, more premature babies are kept alive than formerly, but many of them are burdened with handicapping conditions.

Thus the incidence of severe retardation and other major handicaps rises, and the number of person-years rises faster. That is, the severely handicapped infant who might have required constant attention from birth until he died at age 1, now lives to age 50 or beyond, and needs the same constant care, often in a state hospital bed. As more babies survive birth with severe handicaps, and they live longer, this boosts the demand for bed care geometrically.

President Kennedy declared: "Our goal should be to prevent retardation."¹³ In response, the President's Panel on Mental Retardation asserted: "The key to prevention is an adequate understanding of its causes."¹⁴ This fact points to the need for research, which is treated in Section X of this report.

Some causes of mental retardation are already known, however, and the Study Commission believes there should be more effective use of the information we already have. It has been said (by Dr. Stafford L. Warren, special assistant to the President for mental retardation and former dean of the medical school, University of California, Los Angeles) that if present scientific knowledge were effectively applied, we could reduce the incidence of mental retardation by half.¹⁵

Many cases of mental retardation have their origin before the children are born, because their mothers get inadequate medical care during pregnancy. Sometimes this is because a community lacks proper health services, but more often it is simply because the mother does not know the importance of good prenatal care.

The Department of Public Health has recommended that the Maternal and Child Health program be expanded by intensifying those services which are aimed at preventing mental retardation in high-risk groups of the population. This is one of a series of Departmental proposals for utilizing current knowledge for preventive action,¹⁶ which the Study Commission endorses. By high-risk groups is meant those segments of the California population in which, for economic, cultural and educational reasons, there is a disproportionately high incidence of mental retardation. (See Section I.) The financial resources of these families are meager; their knowledge of community services is limited--but their need for preventive care is high. It is our responsibility to meet that need.

The Department of Public Health has also suggested that it be authorized to establish a section with qualified staff, which would devote full energies to mobilizing public health resources for the attack on mental retardation. The Study Commission recommends that the Legislature authorize such a section to be established in the Bureau of Crippled Children Services. The section would maintain close liaison with Federal resources; coordinate the Department's efforts to control mental retardation through its various resources; and collaborate with the many other agencies, institutions and community organizations actively working on the problem in California. It would, further, have a close and effective relationship with the Regional Diagnostic and Counseling Centers recommended in Section IV of this report.

The Study Commission recommends that the Department of Public Health be given authority to recommend testing for inborn errors of metabolism and related conditions leading to mental retardation in accordance with procedures established by the Department; and the Commission recommends that the Legislature appropriate funds to provide for regional laboratories to carry out such tests.

The Commission urges further that the Department of Public Health continue and increase its efforts to raise standards of prenatal, obstetric and pediatric care at all hospitals in California. The Department should continue to give special attention to county hospitals, as the incidence of prematurity and pregnancy complications is twice as high among the people who use these hospitals as in the general population. Some 53,000 children are born in county hospitals each year; this is approximately 14 percent of all live births in California.

While Federal legislation provides some funds for maternal care for the high-risk mother and her infant, these funds are not large enough to permit the State of California to subsidize routine care of indigent mothers in county hospitals. One of the major obstacles to obtaining obstetrical care

in county hospitals is the widely variable admission policies of the county hospitals. These admission policies were originally established to assure that the county hospital provided care only for the residents of that county. Boards of Supervisors were unwilling to provide medical care to residents of other counties, feeling that they had a responsibility to conserve the locally raised tax dollar.

In order to achieve uniform admission policies and to improve the standard of care in county hospitals, it would appear that at least two actions are needed. The Study Commission recommends that legislative action be obtained to establish statewide, uniform admission policies for county hospitals. The Commission further recommends that the Legislature consider a program of State subvention to county hospitals for maternal care for those hospitals which meet certain recognized standards. It is not possible to estimate the cost realistically at this time, and so the Commission suggests that the subject receive further study, toward the development of firm cost figures.

Regular medical attention and continuing health care in childhood can prevent many cases of mental retardation. Again, it is the people of low income and those with inadequate knowledge of community resources who are the most numerous victims, and again, the Study Commission believes it is society's responsibility to bring the services to the people who need them. We recommend that the Department of Social Welfare include in its medical care program for families with dependent children provisions for prompt and continuous prenatal, obstetric and post-natal care. We also recommend that every local health department alert its staff (especially public health nurses) to the importance of preventive action on mental retardation. The Commission also recommends that programs of public information and education be undertaken statewide and in every community, to let the people know how they can act to prevent mental retardation. (See Section XIII.)

Low socio-economic status, prematurity and mental retardation occur together too often to be coincidental.¹⁷ Despite the advances of scientific knowledge, the incidence of prematurity is rising in the United States,¹⁸ including California. Currently in California there are 28,000 premature births a year. The Study Commission believes the Department of Public Health, in addition to raising standards of care in hospitals, should establish centers for specialized and expert care of premature infants. Prematurity Centers should be accessible to the families who need the service. The Department of Public Health has proposed that a center be a part of every major hospital with an appreciable number of deliveries of expectant mothers. To take care of half the premature babies,

or 14,000 a year, the Department estimates the total annual cost would be \$8,076,600, of which the counties would bear a share, leaving the net cost to the State \$5,693,267 a year.

Elsewhere in this report, the Study Commission offers major recommendations to improve and extend diagnostic services. (See Section IV.) At this point it is important to note that the inter-related subjects of casefinding, diagnosis, registration and genetic investigation are also major tools of prevention. As more is known about the existence of mental retardation, case by case and type by type, it becomes possible to counsel individual families toward avoiding the birth of additional retarded children. Where the cause is genetic but the retardation itself is not, as in phenylketonuria (PKU), testing and counseling can protect the children from becoming mentally retarded.

There are psychological, social and cultural as well as biologic causes of mental retardation. Recent reports from the Federal government emphasize the intimate relationship between low economic status and mental handicap:

"Mental retardation is, without doubt, one of the important causes of poverty. Mentally retarded persons, if employed, are concentrated in less skilled, highly repetitive jobs where earnings are low and where displacement of workers by automation contributes to high unemployment rates even in times of prosperity. Typically, mentally retarded persons have difficulty planning ahead and may let money slip through their fingers regardless of budget. Their care is an expense that may push a family below the poverty line. The Bureau of Family Services reports that large numbers of persons carried year after year on public assistance rolls as permanently and totally disabled are mentally retarded.

"Conversely, poverty breeds mental retardation. The Children's Bureau finds a high incidence of mental retardation in children born to mothers in low-income groups, especially those who have received little or no prenatal health care. The Office of Education finds varying degrees of functional mental retardation among a high proportion of children entering school in areas of long-standing depression, unemployment and cultural deprivation."¹⁹

Many thousands of California youth are functioning below their potential because of cultural deprivation and other socially destructive forces. As noted above in the context of prenatal and child health care, there is a greater prevalence of mental retardation among the socially disadvantaged than in the total population. Because of the very fact of social underprivilege, the deprived families are less likely to use the services

they need the most. It appears to the Study Commission, therefore, that the State and the communities must undertake special efforts first to provide services these people can use to reduce the prevalence of mental retardation, and secondly to develop methods of communicating and motivating these people so they will use the services.

The disadvantaged families are doubly affected: because of inadequate health care and other contributing causes, they have a higher proportion of retarded children than the general population; and because of low cultural and educational stimulation, more of their children perform below their actual capabilities. Although the subnormality of performance is not mental retardation in the physiological sense, it is nevertheless real, and to educators, employers and society as a whole the practical problem appears the same; that is, large numbers of children and adults are performing below the level of capability which society expects of them.

A Senate committee in 1961 disclosed an alarmingly high incidence of physical, mental and social pathology in families receiving Aid to Needy Children (ANC) funds. Among ANC families in a study in Santa Clara County, it was reported, 13 percent had problems of mental deficiency, as compared with the estimated average of 3 percent for the general population.²⁰

Among the ways to attack this huge social problem are direct social services to indigent families and children, retraining of adults for new job opportunities, and compensatory education for retarded children coming from disadvantaged homes.²¹

Large programs are already under way for the amelioration of the living conditions of disadvantaged persons and families; among these are Urban Redevelopment and Renewal and the Federal Economic Opportunity Act. As California engages in the programs authorized by national legislation, the relevance to prevention of mental retardation will be apparent. Nevertheless, effective programs for prevention of retardation and other handicapping conditions also require attention at the more immediately personal levels of health, welfare, education and community services.

Because of the large and continuing influx of newcomers into California, a unique opportunity presents itself at the point where migrants integrate themselves into the new community. The newly arrived person reassesses his potential and has a chance to renew himself and redirect his life. Striving to meet the standards of his adopted community, the newcomer is psychologically ready for change; and in the period immediately following his arrival he is accessible to help in a way which may not be present again. To take advantage of this receptivity, communities must

adopt new patterns of organizing and offering their services. The City of Oakland, with the use of Ford Foundation funds, has had encouraging results in reaching newcomers and, having reached them, in identifying and helping the families of high health risk.

The Study Commission therefore recommends the assessment of projects in California and elsewhere which are designed to integrate and absorb the newcomer into the community of his choice. There must be new social inventions and devices to improve the educational, intellectual and social functioning of individuals coming from more deprived backgrounds than they will encounter in California. Such programs serve many purposes in improving the ability of newcomers to perform effectively, and one of the major results is a reduction in the apparent prevalence of mental retardation.

Among the elements of a comprehensive community approach are preschool programs to prepare children of diverse backgrounds for participation in the public schools; study centers for parents; special school classes for pregnant girls; family discussion groups; youth employment; and the development of positive health attitudes.

Cost of a community program of this scope will run between a million and \$1,500,000 a year, on the basis of the few pilot projects already launched around the United States. To serve the seven largest urban areas in California would cost between seven and eight million dollars a year.

Migration has always been a means of upgrading oneself in America; but the problem of urbanization is the new experience that this country and its people face, and it is especially pressing in the burgeoning State of California. Prevention of slum creation is essential for the continuing health of our cities and their people, and in protecting their physical and mental health we help to prevent retardation.

Section IV.

FINDING THE RETARDED. HELPING THEM TOWARD A LIFETIME PLAN.

Of primary importance--for the retarded child, his family and society--is early, reliable diagnosis. And with diagnosis, to make it meaningful, there must be skilled counseling.

Casefinding and diagnosis may begin at birth. There are in many communities of California, a variety of diagnostic and counseling resources. Among these are the pediatrician, the psychiatrist, the family physician, sometimes even the obstetrician. Among the professions other than medical, there are nurses, social workers, teachers, psychologists, rehabilitation specialists, clergymen. Relatives, friends, neighbors and strangers are often generous with advice.

Effective diagnosis, however, is the responsibility of qualified persons, preferably working as a team. The professional disciplines should include medicine, psychology, social work, nursing, education, speech therapy, nutrition and others as needed. For comprehensive medical diagnosis, it is essential that there be available the specialized skills of pediatrics, psychiatry and neurology.

Professional teams of this complexity and skill are not available in every community, and never can be. The retarded child, however, may be anywhere. It is therefore essential that basic diagnostic skills and counseling services be available to every family in California, close to their homes and readily accessible. Backstopping the first-line community services, there must be a statewide network of diagnostic and counseling teams to whom the community general practitioner can refer the family of anyone suspected of mental retardation and associated handicapping conditions.

To this end, the Study Commission on Mental Retardation recommends the establishment of Regional Diagnostic and Counseling Centers throughout California. This proposal accords with a recommendation of the Assembly Interim Subcommittee on Mental Health Services.²²

The Regional Centers can be the means for bringing to the family of every child with developmental problems the resources it needs to learn about the handicap and to begin to make an appropriate lifetime plan. Each Center would have the staff and facilities required to establish definitive diagnosis. It would also offer professional counseling to the family immediately after diagnosis and on a continuing basis as needed; it would provide the

link between the family and the community's resources, including the Departments of Education, Mental Hygiene, Public Health, Rehabilitation and Social Welfare; it would help the family select the appropriate service for the retarded person and assist in making the arrangements, including financial; it would be a continuing resource for the retarded individual and his family; it would maintain a registry; it would establish relationships with teaching institutions and residential facilities; and it would stimulate opportunities for applied research and for professional training.

In short, the Regional Diagnostic and Counseling Center will provide one door--the "fixed point of referral and information" recommended by the President's Panel²³--through which the retarded person and his family can enter to obtain the help they need. (This does not mean, however, that the Regional Center need necessarily be a single building or a group of physical structures. Rather, it is to be group of services, all available to the individuals and families that need them.)

Diagnosis acquires meaning only as it is interpreted to the parents through skilled counseling. All members of the diagnostic team may have a positive role in the first interpretation of the diagnosis. Thereafter, continued counseling may be best provided by the social worker, the public health nurse or other qualified professional, depending on the degree of the child's handicap and the parents' level of understanding.

It is the hope of the Study Commission that by 1970, if not sooner, the family of each retarded person may have a variety of choices as to the type of care he should receive, within a broad range of suitability determined by skilled and informed professional people. (See page 78.) For such a choice to be meaningful, there must obviously be a variety of services in existence; equally important, the family of the retarded individual must have sound counseling. The presentation of appropriate alternatives, and the provision of counseling, will be major responsibilities of the Regional Center staff.

In addition, the Regional Center staff will gather information about the resources of the retarded person and his family, will determine eligibility for public and private services, and will assist in assembling funds for use of the retarded individual in purchasing services.

For the community, each Regional Center will become the hub around which existing resources can be arranged, and through which new services may be established. It will also serve as an arm of the State in defining and interpreting standards of community care for the mentally retarded.

The Study Commission recommends that the Legislature place responsibility for establishing the Regional Centers on the Department of Public Health. Each Regional Center may be operated under a variety of sponsorships depending on the resources available in a particular locale. These sponsorships could include any of the following: Department of Mental Hygiene, community mental health programs, private hospitals, university centers. On the next page appears a chart indicating how a Regional Center would operate and what relationships it would maintain with other State and community agencies.

Each Regional Center should have a core professional staff, augmented by consultants representing additional fields and specialties. A typical staff organization pattern might follow these lines:

A. Professional

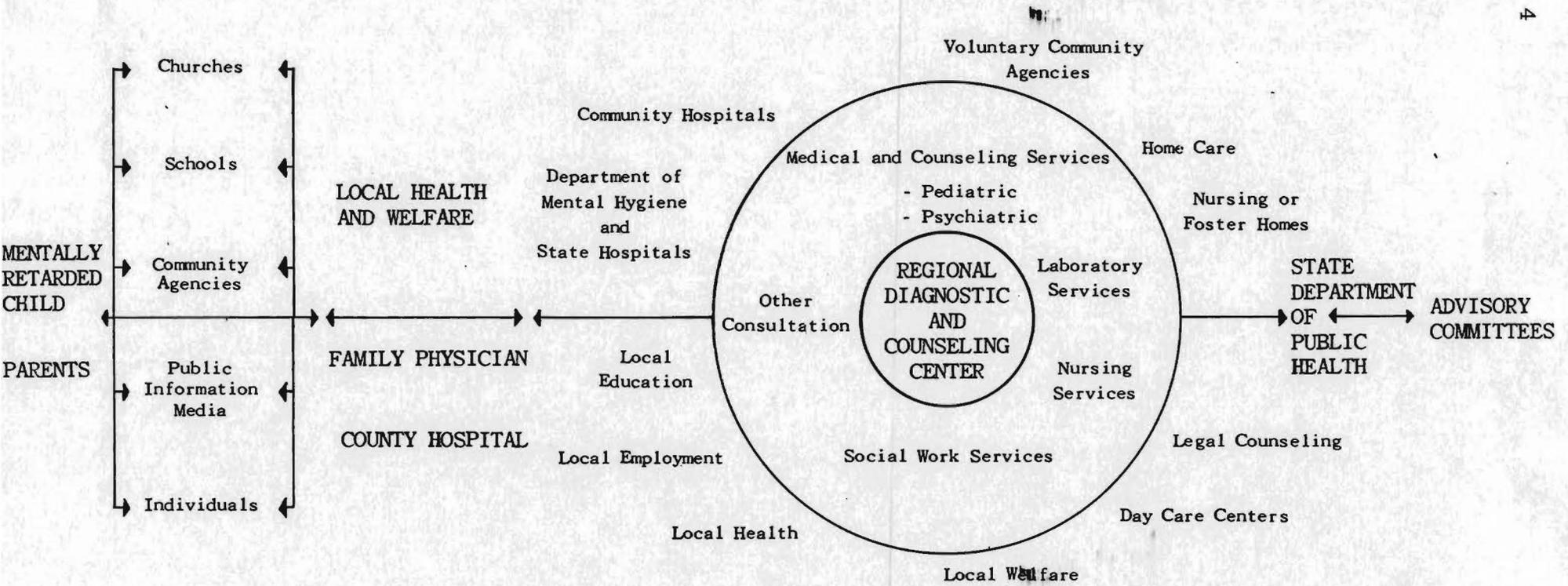
| | |
|-------------------------------------|--|
| Physician | - Board eligible or certified by an appropriate American Specialty Board |
| Social Worker | - With a Master's degree |
| Psychologist | - Certified by the State of California--with a Ph. D. degree |
| Public Health Nursing Supervisor | - Preferably with a Master's degree in public health |
| Educator | |

B. Non-professional

Secretary
Nurse's Aide

C. Consultants--part time - Fee for service basis

Dentist
Hearing and Speech Consultant
Metabolic Consultant
Neurologist
Nutritionist
Ophthalmologist
Orthopedist
Pediatrician (if not on staff)
Psychiatrist (if not on staff)



The services of a Regional Diagnostic and Counseling Center should be available within reasonable distance of every California family which may have a retarded child. Insofar as possible, "reasonable" shall be interpreted to mean within two hours' driving distance. When it is difficult for a family to get to the Center, transportation should be provided.

The Centers should be located close to population centers where they are most needed, and wherever possible in proximity to institutions of higher education and research. In some areas of the State, two or more counties would constitute a single region, because of the level of community resources and the number of families to be served. Elsewhere, one county might constitute a region. In the Los Angeles area, several Regional Centers may be needed to give the coverage necessary. ²⁴

In sparsely settled areas, it is not always practical to provide a fully-staffed Regional Center within reasonable distance of every family. In such cases, the Study Commission recommends that the Regional Center organize traveling diagnostic teams, bringing mobile clinics to the rural areas. On their periodic visits to remote communities, the traveling teams would also stimulate the development of local services and help to train local professional workers in the skills necessary to diagnose mental retardation and to counsel the families.

The Department of Public Health believes that ten Regional Diagnostic and Counseling Centers, with traveling clinics for surrounding counties, can be in full operation within three years after they are authorized, at a total annual cost of \$1,500,000. With the expectation that six centers may be established during the first year, the Department suggests that the cost during fiscal year 1965-66 will be \$900,000.

The Study Commission wishes to emphasize that diagnosis and evaluation is not a one-time task. It calls for periodic review and revision. The Regional Center can arrange for systematic follow-up on children in their preschool and later years. As the retarded child progresses through the school years, evaluation becomes a useful tool in designing appropriate prevocational training and, ultimately, proper placement of the retarded adult.

When there is evidence or suspicion of a hereditary aspect to retardation, the Regional Center will have a special responsibility to investigate the genetic aspects. Adequate sources of known genetic information should be available to all families who seek it, with special emphasis on those known to harbor recessive genes that may cause mental retardation.

Section V.

HOME AND COMMUNITY SERVICES

The Study Commission accepts the principle that the closer to home services for the retarded are provided, the better it is for the retarded person, his family and society. As a committee of the California Medical Association put it, "Services to be most effective must be given as early as possible, as continuously as possible, as close to home as possible and with as much social restoration as possible."²⁵

As the community provides for all children and other citizens needing services, it has an obligation to provide also for the retarded. Schools, libraries, parks and other recreational services, transportation, a pure water supply are among the services afforded in each community. To the extent that retarded persons can benefit from these services in their home areas, they should have access; to the extent that the retarded need special services because of their special handicaps, these should likewise be available under local auspices, insofar as possible. In this context, the "community" includes departments of local government, voluntary agencies and private entrepreneurs.

The Commission believes that, insofar as he is able to benefit, the retarded individual should share in community services available to every citizen. This includes recreation, group activities, religious guidance and certainly the services of the public schools. It has been correctly said that for most of the retarded, the dictum of the Supreme Court regarding racial minorities is applicable: that separate facilities are inherently unequal.²⁶

To the extent that services are local, planning and coordination are likewise local responsibilities.

For effective service to the mentally retarded and their families, every community must have a plan. While the State should not dictate the details of such a plan, the State does have a right and an obligation to insure the provision of adequate services for all its citizens, and it should therefore require a comprehensive planning process as a condition to the supplying of State services or State funds. The pattern of the local planning agency is a matter for each community to decide, but the State should specify the minimum standards for development of local plans and programs.

Research and professional training can and should be intimately bound up with service programs for the retarded. When appropriate, such resources as diagnostic clinics, special education centers and sheltered workshops for the mentally retarded should also serve as facilities for research and professional training. Institutions of higher education should seek out these resources and use their potential; and the community programs should cooperate fully.

Recording of information is important, not only for proper service to the retarded individual and his family but to indicate to the community the scope of the problem and to enable realistic planning to meet the long-range needs of all the retarded. There is not now a law requiring registration of the handicapped, as exists in some European countries,²⁷ but as organizations and agencies undertake to provide services in the community, they should accept as part of their responsibility the keeping of usable records.

Direct services to the retarded person and his family begin with comprehensive diagnosis and counseling, as recommended in the preceding section. Once the diagnosis has been made, however, the retarded child needs to receive a variety of services, some because he is a child and some because he is retarded. (The word "child" is used in this context because it is anticipated that when the Regional Diagnostic and Counseling Centers are in operation, mental retardation will be discovered at an early age.)

As retardation is often accompanied by other handicaps, regular medical attention is desirable. In cases involving emotional disturbance, this may include psychiatric care. There may also be special dental, optical and other needs. In each community there should be professional people who are aware of the special needs and limitations of retarded children and who are willing to work with these sometimes difficult patients.

An early need following diagnosis often is home training for the young retarded child--training which benefits the mother and the rest of the family as much as it does the child himself. Many young mothers need help with infants, and the tasks become more complex and difficult when the youngster is retarded. The public health nurse, the nursery school teacher, the homemaker or in some circumstances the social caseworker can help start the training of the retarded child and relieve the mother's distress by home visits and demonstrations.

For families with children who have multiple handicaps, home nursing service should be available.

Adults who are mildly retarded may be enabled to live at home if they receive occasional visits from a public health nurse or homemaker. Those who are physically handicapped as well as retarded may also remain at home if their families receive regular help with the physically demanding tasks of caring for the handicapped one.

An agency offering such services should train its staff in the special aspects of home training for the retarded.

The parent organization (local association for retarded children) can play a valuable role in family adaptation. The knowledge that other families have had similar experience is a consolation to the new parent; there is also a reassurance and an informal therapy in being able to discuss the problem with others, and to participate in group discussions and activities in behalf of the retarded.²⁸ The association for retarded children also offers reading lists and usually maintains a library on mental retardation.

As the retarded child grows older, the family's problems take new forms, and there may be need for fresh counseling. Sisters and brothers may pose new problems as they grow older, and as the parents approach their senior years they become more concerned about lifetime protection of the retarded member of the family. (See Section VIII.) Counseling should be readily available whenever any member of the family needs it.

The retarded person himself may need counseling and guidance at various times during his life. Again, the Regional Center is a major resource, but it must be supplemented by services close to home. For many retarded adults, care in their own families or foster care may be the only lifetime plan required, but it may require outside support. When these people are needy and receive support from the public assistance program, the county welfare department should be equipped to give continuing casework service.

The family of every retarded person should have close and convenient access to a central information and referral facility, for guidance and direction on problems associated with mental retardation. The Regional Diagnostic and Counseling Centers will provide the principal points of a statewide network, but where a Regional Center is not nearby the community should provide the information and referral service. In the discretion of the individual community, this service may be provided by the county welfare department, the county health department, the county or city superintendent of schools, the community welfare council, the local association for retarded children or other local service center.

No less important, but complementary to family counseling services should be efforts to orient communities generally regarding the phenomenon of mental retardation: how to recognize early signs and symptoms, where to find community resources to assist the child and his family. Moreover, there is need for a demonstration of the effectiveness of training programs designed to orient communities concerning the acceptance and usefulness of mentally retarded individuals in the community.

Because mental retardation is not a specific ailment, there is no treatment for the condition itself, although some of the causes are amenable to treatment. The objective for each retarded individual is training, education, habilitation so that he may develop to the limits of his capabilities.

Associated with mental retardation, however, there are often physical and emotional conditions which aggravate the basic handicap. To the extent that the allied handicapping conditions can be alleviated, the effect of the retardation may be minimized. It is therefore important that professional people in each community accept a responsibility to serve the mentally retarded with skill, insight and compassion. Among the professions often important to multiply-handicapped retarded persons are the pediatrician, the surgeon, the psychiatrist, the psychologist, the dentist, the ophthalmologist, the optometrist, the nurse and the educator.

The area of psychiatric treatment may be important to the family as well as to the retarded individual. The Council of the American Psychiatric Association has said: "The mentally retarded child faces very special hazards in developing the ability to handle life's stresses... (He) is particularly subject to emotional disturbances which must be diagnosed and treated. The psychiatrist brings to this configuration of hazards a competence in identifying the presence and degree of emotional disturbances as they may inhibit learning, impair thinking and distort perception."²⁹

All of the diagnostic categories of emotional disturbance, including major mental illness, are to be found in those with mental retardation and, when present, require psychiatric treatment. In addition, the families of the mentally retarded individuals are subject to special emotional hazards which often require skilled professional therapeutic intervention.

Section VI.

EDUCATION, REHABILITATION, EMPLOYMENT

To help each retarded individual reach the limits of his potential requires a rehabilitative concept from early childhood. As the president-elect of the American Association on Mental Deficiency put it recently, "The true goal of education and rehabilitation of the mentally retarded individual is to help each one make the most of his potential to work and actively participate in the affairs of his community, no matter how limited his potential may be."³⁰ Education, for the retarded child, may mean the learning of such simple skills as self-care in feeding and dressing; for the relatively less retarded it will include some academic knowledge. To be of maximum use, the educational program should begin early and continue, in various forms, throughout the life of the retarded person.

More than five years ago, a joint Legislative committee, under Senator James J. McBride, chairman, and Assemblywoman Dorothy Donohoe, vice-chairman, offered these principles:

"The mentally retarded are more like persons of normal mental ability than they are different from them. As children they are entitled to education opportunities to the extent that they are capable of benefiting from them. As adolescents they have the same basic needs as other young people for social contact and opportunity for social development. As chronological adults they have the right to engage in the maximum constructive self-directed activity of which they are capable."³¹

Preschool Services

Because retarded children are socially immature they need longer and more closely supervised experience in socialization. The individual's need will vary with his mental age and other considerations, to be sure, but preschool activities should be available for the retarded child at least from the age of 3 on. These may include day care, nursery schools and preschool training centers.

Shortly after his appointment as director of the division of handicapped children and youth in the U. S. Office of Education, Dr. Samuel A. Kirk met with the California Study Commission on Mental Retardation. On the basis of his own research and the work of others, he offered the estimate that 50 percent of the apparent retardation in school-age children can be

prevented by early action. Dr. Kirk suggested preschool programs which would begin at age 2, 3 or 4. Compensatory educational services for slum children at an early age, he said, could prevent progressive retardation in the school years.

In addition to the value for the child, the day care center and the preschool program provide welcome relief for the parents--especially the mother--from the 24-hour demands of a handicapped and often hyperactive child.

An integral part of a good preschool experience is the parent education which comes through regular meetings with other parents and discussions with the teacher. Volunteer participation, or at least periodic observation, also helps the parent to see the child's progress and social interaction with more objectivity. Indeed, local associations for retarded children have served both the youngsters and their families by sponsoring day care centers.

The pilot child care centers for the mentally retarded and the physically handicapped, as originally proposed by the joint interim Legislative committee in 1959,³² have demonstrated their potential for solving a community need. The two which have been operating longest, in Stockton and in Oakland, have been praised by school officials and community leaders and have been deeply appreciated by the parents of the children in attendance. In the past year, a third and a fourth center have been opened, in San Jose and in Seaside (Monterey County), thereby filling the quota authorized by the Legislature.

Believing that the pilot child care centers have proved their value, the Study Commission recommends that the Legislature provide a statewide system of child care centers for the mentally retarded, and that it provide adequate financial support for capital outlay, operations, transportation and administration. The centers should operate under auspices similar to the present four--that is, under the local or county school system, with cooperative provision of services by other local agencies and with financial assistance from the State. Consideration should be given to funding arrangements which will permit the Department of Social Welfare to contract for portions of service which come within its jurisdiction.

Experience at the two oldest child care centers indicates that the financing has been inadequate. Additional funds are needed to provide adequate staffing and ancillary services, including psychological services and transportation. The Department of Education estimates that an appropriate budget for a child care center serving 30 to 35 retarded children

would be \$51,600. The Department reports that in addition to the four pilot child care centers now in operation, ten communities have expressed interest in establishing such centers and would be ready to begin operations in the next fiscal year. The total appropriation required for the 14 programs during the school year 1965-66, therefore, would be \$722,400.

Special Education

California has been a leader among the states in provision of special educational services for exceptional children. Since 1947, when mandatory legislation was enacted, there has been an impressive growth in classes for "educable" retarded children, to the point where, in the school year 1963-64, there were 48,388 such youngsters in special classes in the elementary and secondary schools. Comparable mandatory legislation for "trainable" retarded children became effective July 1, 1964, and a substantial growth in programs may be anticipated in the years immediately ahead, but even under the voluntary program for the more severely handicapped children, there were 4,207 enrolled in special classes in the school year 1963-64. As of October 31, 1963, therefore, there were 52,595 mentally retarded children between the ages of 5 and 21 enrolled in the public schools of California.³³

Nevertheless, the State and the school districts have a long way to go. The Department of Education has estimated that the number of "educable" mentally retarded attending special classes in the public schools is only 63 percent of the potential of total enrolment at the elementary and secondary levels.

The estimate is based on theoretical figures as to prevalence, however, and part of the problem is the fact that many of the children who need special services have not been identified or located. As noted earlier in this report, statistically reliable information on the prevalence of mental retardation is scarce. In order to make proper provision for the children needing special educational services, the schools must identify those who are underprivileged, the slow learners and the mentally retarded. The Commission therefore recommends that the State make financial assistance available to school districts to inaugurate systematic and periodic surveys to locate and effectively identify these children. With thorough-going search and testing, the Department of Education estimates that more than 13,000 retarded children could be evaluated during the next year. To do so would require the services of the school psychologist, school nurse, social worker and teacher; and considering the time required for case conferences, the cost would average \$100 a child, or a total of \$1,300,000 for the year.

To finance this would mean an addition of \$30 per unit of average daily attendance to the excess cost structure. In difficult cases, the schools may make referrals to the nearest Regional Diagnostic and Counseling Center (see Section IV).

Despite the Legislative mandate for education of retarded children, as noted above, the coverage is still less than complete, and the situation is worse at the secondary than at the elementary level. There are 37,234 "educable" mentally retarded pupils enrolled in special classes at the elementary school level, representing 65.9 percent of the potential as estimated by the Department of Education, but at the high school level there are only 11,154 in special classes, representing 54.9 percent of the potential. This suggests that far more youngsters are dropping out of school in the junior and senior high school years than is proper for them, or for the society in which they will live.

The Study Commission proposes several steps to remedy the situation: That each high school district provide a four-year high school program to every "educable" mentally retarded youngster; that city boards of education and county boards of education having responsibility prescribe and enforce a high school curriculum designed to meet the needs and develop the potentialities of the mentally retarded; and that the governing board of each high school district evaluate administrative practices of the district relating to its programs for the mentally retarded. Among the items which should receive scrutiny are policies and practices concerning exemption, expulsion, drop-out, graduation, and the issuance of diplomas.

The housing of special education services is another area requiring improvement. California school systems have long been hard pressed to provide classrooms for the mounting school enrolment. The situation has been no less acute for handicapped pupils, and indeed in some communities the exceptional child has been relegated to inferior physical surroundings.

Over half of the classes for the educable mentally retarded are housed in classrooms built for non-handicapped pupils. Such classrooms are not designed to promote the curriculum objectives appropriate for these pupils. Many classes for the educable mentally retarded continue to be housed away from the regular schools in abandoned schools, barracks, quonset huts, and other inappropriate facilities.

The classroom picture for the "trainable" mentally retarded is even less satisfactory than for the "educable." Many classes are located in facilities that frustrate the training objectives of the program.

Poor classrooms contribute to staffing problems. There is a 15 percent attrition every year in the teaching force in the area of the mentally retarded. The kind of classrooms contributes to this high attrition picture. Knowledge of the poor classrooms to be found in the area of the mentally retarded also impedes the recruitment of young persons to programs of teacher preparation for the area of the mentally retarded.

In too many school districts, classes for the educable mentally retarded are moved several times during the school year. This is difficult for pupils and teachers and frustrates any significant integration of the children with other school youngsters.

To help the schools cope with the limitations imposed by poor housing of special-education classes, the Study Commission recommends that the State provide for one-half the cost of all classrooms constructed for the mentally retarded. The Commission also recommends that the State extend school building aid to county superintendents required to provide schooling for retarded children and youth where the district in which the program should be located does not qualify for such school building aid. These proposals require changes in the law, but they do not call for new funds beyond what is now available in State school building aid money.

If the school districts and the county school superintendents are to provide the improved services proposed in this section, they will need financial assistance beyond their present resources. To help them, the Study Commission proposes that the Legislature reserve a larger amount than the present \$9.63 per unit of average daily attendance, to finance the special-education program. The transfer of money from the General Fund to the State School Fund should be sufficient to reimburse up to 100 percent of the ceilings authorized for special education.

In areas of the State where it is not feasible to establish a special training class, the county superintendent should have authority to pay the room, board, transportation and tuition for a retarded child enrolled in a program provided by another district or county or by a private school, in accordance with the financial responsibility formula (see Section IX.) The county of residence should pay any costs beyond those paid by the State, including a reasonable charge for the use of classrooms and equipment.

To achieve a smooth transition for retarded adolescents from public schooling to work training, it is desirable to provide vocational training while the youngster is still attending school. Recommendations to this end appear elsewhere in this section. For the moderately retarded (those the schools consider "trainable"), transportation between the school and work station is a need which the State should help meet. In 1963-64

there were 4,207 youngsters enrolled in such programs. Assuming that 10 percent of them would need transportation, at an average cost of \$200, supplementary funds in the amount of \$84,000 would be required for the next school year. The Department of Education anticipates that by the school year 1970-71, there would be 9,278 such youngsters enrolled, and the transportation cost would amount to \$185,400.

The Study Commission also recommends that the Department of Education work with the Department of Rehabilitation to obtain Federal funds to implement work experience education and occupational training programs. To the extent that Department of Education programs provide rehabilitation services, the Department of Rehabilitation should contract and pay for these services.

The growth of special classes for the mentally retarded in California public schools over the past ten years has been phenomenal. As a result, some teachers were persuaded to accept assignments even though they had little special preparation, and others were drafted into leadership roles with little or no special training or experience in education of the retarded.

To continue the improvement of special education programs for larger numbers of retarded children, the Study Commission recommends that the Legislature continue and increase grants to teachers of mentally retarded minors as authorized under the provisions of Education Code, Sections 6875-6878.

Under the law governing licensing of certificated personnel, as amended in 1963, all teachers getting additional credentials must meet the new credential requirements, which include fulfillment of an academic major. There is an unforeseen and unintended effect of this law which will deprive retarded children of some excellent teachers. In order to receive credentials to teach the mentally retarded, teachers are now required to fulfill the academic major, even though they may have been teaching successfully in the regular classes of elementary school for years. The effect is to close the door to special education for the elementary school teachers who now hold credentials, and many of these teachers have been among the best recruits to special education of the mentally retarded. For them, it is inappropriate to require credentials in an academic major. The Commission therefore recommends that the Licensing of Certificated Personnel Law (Education Code, Sections 13187-13197.7) be amended so that its provision requiring an academic major does not apply to teachers already credentialed and teaching in the public school system who seek to enter the field of special education.

Adult Education

Some retarded adults will go from special classes to vocational training centers and sheltered workshops. Others, however, could benefit from adult education programs in a classroom setting. The problems, as with school-age retarded children, have to do with finances, personnel and physical facilities.

There were in 1963 only 26 adult education classes reported to be serving the mentally retarded. The average enrolment in adult education classes is 31 students. For the mentally retarded, however, a class should be no larger than 15. The Study Commission therefore recommends that excess cost reimbursement be made available to school districts in the amount of \$350 per unit of average daily attendance, in order to enable the districts to provide special education services for retarded adults without incurring deficits. The Department of Education predicts that there would be, in the school year 1965-66, 34 such classes with an enrolment of 510. The total cost to the State would be \$255,000, of which \$178,500 would be beyond the present rate of reimbursement. To the extent possible, these services should be provided under contract from the Department of Rehabilitation.

Vocational Opportunity

Vocational opportunity should be available to every mentally retarded person to the extent that he is capable of using it. This principle has practical implications with respect to the retarded person; the evaluation, training and counseling he receives; the attitudes of prospective employers and the general public; and finally, the changing job market and the total pattern of the California economy. Thought must also be given to the provision of community services for the retarded adult, so that when he is vocationally and socially capable, and when he and the job have been brought successfully together, he will have at his disposal the other community resources necessary to enable him to live as a contributing citizen.

The National Rehabilitation Association recently acknowledged that "rehabilitation programs for the mentally retarded. . . lag far behind programs for the rehabilitation of the physically handicapped."³⁴ This is a situation which must be corrected in California.

Estimates indicate that one of every three mentally retarded youth leave high school each year, either by graduation or dropout. In 1965-66, this will represent over 3,500 young adults with limited mental capacity who

will need assistance if they are to become self-supporting. By 1970, this yearly number will have grown to over 6,500 and in 1975, it will be almost 11,000.

In addition, many retarded children drop out of school before they reach the secondary school level. Unlike the normal child, most mentally retarded individuals, in spite of intensive work by the public schools, are unable to obtain or retain employment by the time they leave school at the age of 16 to 21. After leaving school some may find their way into adequate employment, but the majority become dependent upon their families or community, and many create serious community problems.

The solution must begin much earlier. Evaluation, and social and prevocational training, should begin in the school years. Transition machinery should be developed so that, years before the retarded youngster "graduates" from special education, the community is aware of his potential and his limitations and is preparing to help him move along the next steps. Family, diagnostic clinic, school and rehabilitation resources must work together.

Cooperation among agencies is essential. School officials, rehabilitation counselors and employment specialists should be in regular consultation with reference to each retarded youngster who is moving along the continuum from special education and training to employment. The Department of Rehabilitation should assign rehabilitation counselors to schools at the request of the school districts; the Department should also encourage local training centers and sheltered workshops to work closely with the schools. The Department of Employment should direct its local offices to be alert for job opportunities for retarded workers, and to provide special services as necessary, working cooperatively with rehabilitation counselors to insure that retarded workers are placed in appropriate jobs and are helped to succeed.

At the present time, a considerable number of retarded persons are in state hospitals for the mentally retarded who ought not to be there--and who would not be there if there were alternative services. (See page 71.) Many of these individuals would benefit from vocational evaluation, occupational training and careful job placement under the guidance of a rehabilitation specialist. The Study Commission therefore recommends that the Department of Rehabilitation establish operating rehabilitation units throughout the State in close cooperation with all state hospitals for the mentally retarded. This staff would be assigned to assist the hospital workers in directing vocational services. They would also be available to develop and coordinate the various vocational services to be operated under joint agreement with the Department

of Mental Hygiene using Federal Vocational Rehabilitation funds. Having staff assigned to the hospitals would permit the development of a vocational bridge between the hospitals and the community vocational rehabilitation services. As the retarded who can benefit from vocational training and habilitation are moved out of the state hospitals, and as alternative residential services are developed for retarded children and adults who do not need hospitalization, the Department of Rehabilitation should place similar operating units in the new residential facilities.

To give adequate rehabilitation service to the adult mentally retarded, services should start at whatever time the individual is ready for prevocational activities. It has been found that with most mentally retarded young people, some services can be started during the time they are in secondary school classes. It will be possible, through implementation of Sections 6818, 6976, and 6912.5 of the Education Code, to place vocational rehabilitation counselors, from the Department of Rehabilitation staff, in high school districts. The counselors should work closely with special education personnel to develop vocational oriented programs for mentally retarded students, and to integrate these programs with the field services of the Division of Vocational Rehabilitation following the students' separation from public school programs.

The Study Commission further recommends that the Department of Rehabilitation be authorized to develop contracts with any school district where it is possible to use existing school services to match Federal Vocational Rehabilitation funds to provide rehabilitation counselor service to the schools. At least 25 school districts are now in a position to develop programs of this kind in cooperation with the Department of Rehabilitation. No additional State funds will be needed to carry on this program. It is likely, however, that additional legislation will be needed.

The first step in successful counseling and placement involves determining the vocational potential of the retarded individual. This may call for a complete diagnostic review, job sampling and specialized tests. Then, as the individual's capabilities become apparent, there should be a range of community resources to which he might go: training center, activity center, sheltered workshop (transitional or terminal) or competitive employment with minimal supervision.

A most important development for the adult retardate in California has been the increased workshop services for the retarded. At the middle of the century there were no workshops for the retarded in California. In 1964 there were more than 30 work training centers for the retarded. In 1958 two workshops serving all disabilities accepted the retarded; in 1964 more than two dozen multi-disability workshops served the retarded.

Over the years, the California vocational rehabilitation agency has repeatedly emphasized the crucial role of the workshop in serving the mentally retarded and other severely disabled. Through its workshop consultant service the Department of Rehabilitation is assisting community groups in establishing and improving workshops which have proved to be of substantial value in providing vocational evaluation, job tryout, work adjustment, and actual vocational training. Public Law 565 has provisions for the utilization of Federal funds in the establishment and expansion of workshops providing the necessary State or local financing is made available.

Impressive as the increase of workshop services for the retarded has been, there is general agreement that workshop services for the retarded will have to be increased many fold if the retarded adult is to be well served in California. There is at present no complete agreement as to the best way in which the needed additional workshop services should be sponsored, organized and financed. The determination of the most constructive course of action to expand workshop services is a task toward which public and private agencies should address themselves as a matter of high priority in the near future.

Work training centers and sheltered workshops may be offered for retarded persons under a variety of auspices. Local associations for retarded children currently sponsor such services, and the workshops of other organizations are often open to the mentally retarded. (See page 39.) Not only should all such programs be encouraged to continue and expand, but the Study Commission believes additional auspices should be found for sponsorship of work training and sheltered employment of retarded persons.

Since September 1963, the Departments of Rehabilitation and Social Welfare have been cooperating on a program to serve mentally retarded recipients of Aid to the Disabled (ATD) through the use of sheltered workshop programs. This cooperative service involves the active participation of county welfare departments, and in recent months has begun to prove itself to a significant degree. At the present time, the program is financed by a State appropriation of \$30,000 to the Department of Social Welfare, matched by a Federal grant of \$90,000 to the Department of Rehabilitation; and with these resources service is being given to 200 ATD recipients. The Study Commission recommends that the Legislature continue the program and increase the State appropriation to \$60,000, which will be matched by \$180,000 in Federal funds.

A sound program for developing employment opportunities for the retarded must take into account the range of their capabilities and limitations. It must include identifying jobs which could be performed satisfactorily by particular groups of the retarded, identifying the conditions under which satisfactory job performance could be made possible in these jobs or how the jobs could be adjusted to insure satisfactory performance, and developing information about successful performance on such jobs. Training the retarded for employment could then be closely tailored to help each one prepare for specific job opportunities that promise satisfactory and permanent employment in a particular community.

Mentally retarded men and women have successfully filled a wide variety of jobs calling for an impressive range of skills.³⁵ The record suggests that employment opportunities can be expanded for many more carefully chosen and trained individuals, if good judgment is used in selecting the occupations and establishments in which employment opportunities are developed. In fact the U. S. Department of Labor recently estimated that more than 85 percent of the mentally retarded are capable of acquiring job skills and working in a normal, competitive employment situation.³⁶

Experience suggests other steps necessary to expand employment opportunities for the retarded.

A first step is selection and training of the retarded person to be sure he qualifies for the job to be filled. Tests have recently become available through the California State Employment Service to measure the employment potential of individuals who are mentally retarded (as distinguished from those who are culturally handicapped). A great deal more needs to be done in the field of vocational test development to identify the mentally retarded who have a good employment potential. Nevertheless, it is possible at the present time to select good placement risks for specific jobs by using the available tests and carefully evaluating the experience of retarded individuals in training courses and workshops.

Another important part of a positive employment program for the retarded is a realistic appraisal of the job opportunities open to them, or that can be developed for them. Such an appraisal must be made in the light of the general manpower situation in present-day California. The direction in which job opportunities are sought and developed will be sound only if the realities of the California labor market are understood and taken into account. In this task the Department of Employment has a key role.

Beyond selection and training of the retarded person for the particular job, there is the task of preparing the employer and others with whom he will come in contact. In one respect, this is a broad-scale public relations problem in which many agencies, public and voluntary, will have a part. The President's Committee on Employment of the Handicapped, the Governor's counterpart committee in California, and other agencies have been working to inform employers that the qualified retarded person can be an asset on the job.³⁷

The Hayward Union High School District has developed a training program for high school boys to become custodian's assistants. Growing out of this program has been a publication³⁸ which is at once a handbook for the trainees and a tool to show prospective employers how the young men have been trained and what they can do. This is a creative melding of program service with public relations.

Another encouraging approach is the proposal currently being developed by California locals of the Building Service Employees International Union, AFL-CIO. The plan is that the union will directly assist in job placement of handicapped workers, including the mentally retarded, on referral from public and private agencies.

In addition to organization efforts, the opening of job opportunities through changing employer attitudes is a task which skilled rehabilitation and placement specialists must conduct on an individual, face-to-face basis. This implies a strong community program. The Study Commission proposes that vocational rehabilitation units for service to the mentally retarded be established in connection with all major offices of the Department of Rehabilitation. Personnel in these units will dovetail their services with all public and private community services for the mentally retarded. This will include the services provided by the Department of Mental Hygiene, as well as the proposed Regional Diagnostic and Counseling Centers, community mental health centers and facilities for the mentally retarded as provided for through Public Law 88-64 and other community services for the mentally impaired.

Past experience of the Vocational Rehabilitation staff indicates the mentally retarded achieve their maximum point of usefulness if one person coordinates the entire range of services and continues a supportive counseling relationship through a fairly long period of adjustment following placement on the job or in the home. This is the role of a vocational rehabilitation counselor. The counselor ties together the many purchased services and continues necessary counseling service from the point of evaluation through to the final adjustment on the job, whether it be in competitive employment, sheltered employment or as a helper in the home. Without this type of continuous supportive counseling and coordination of services the many community services for the adult retardate become a jigsaw puzzle with many of the pieces missing or lost. It is recommended that these vocational rehabilitation units for the mentally impaired be manned, statewide, by 50 vocational rehabilitation counselors and supporting staff.

While some of the foregoing proposals will require substantial sums of money, much of the program can be financed with matching funds from the Federal government. Following is a summary of the new program proposals offered by the Department of Rehabilitation and endorsed by the Study Commission.

1. Add eight vocational rehabilitation counselors with case service funds and supporting staff to the state hospitals for the mentally retarded. It is estimated that this program will provide vocational rehabilitation services to approximately 400-800 patients each year.

Cost: \$320,000 Federal funds: \$160,000 State funds: \$160,000

2. Develop Department of Rehabilitation contracts with school districts to provide at least 25 additional counselors with case service funds and supporting staff for service to the mentally retarded students. It is estimated that 2,000-3,000 students will be given vocational rehabilitation services through this cooperative program.

Cost: \$625,000 Federal funds: \$625,000 State funds: None

3. Establish vocational rehabilitation service units for the mentally impaired with primary emphasis on the mentally retarded in all major offices of the Department of Rehabilitation, using at least 50 vocational rehabilitation counselors with case service funds and supporting staff. It is estimated that 3,000-5,000 additional people could be served each year through this program.

Cost: \$2,000,000 Federal funds: \$1,000,000 State funds: \$1,000,000

4. Expand sheltered workshop services for the mentally retarded Aid to the Disabled (ATD) recipients. This program has been designed to serve the severely mentally retarded who are not normally served by programs indicated above.

Cost: \$120,000 Federal funds: \$90,000 State funds: \$30,000

Because the State of California is itself an employer utilizing a variety of skills, the Study Commission recommends that the specialized placement program of State government should be equally at the disposal of the mentally retarded. The State Personnel Board and all agencies and departments of the State should make every effort to place retarded persons in jobs for which they qualify. It is recognized that this may require a modification of present testing and interviewing procedures, to minimize the weight given to verbal facility, but this must be done if there is to be genuine equality of opportunity on the basis of qualifications. A continuing effort is required to analyze and redefine State job requirements so that more of them may be open to retarded persons.

In recent months the U. S. Civil Service Commission has undertaken to analyze jobs in the Federal civil service that are suitable for or could be adapted to successful performance by the mentally retarded, and is setting

out on a course of action which will allow some of these jobs to be filled by the mentally retarded. Early reports (for example, from the U. S. Post Office in New York) are encouraging. This pioneering effort should be followed closely, because it undoubtedly will disclose job opportunities suitable for the retarded in other public employment.

One rather unique area in which the State may employ retarded persons is in work with the more severely retarded.³⁹ This is especially appropriate in state institutions, and has the added advantage of relieving in some measure the shortage of personnel. (See page 96.) Clearly, the retarded must have careful supervision as they work with other handicapped persons, and it must not be expected that they can replace more highly skilled employees, but with thousands of institution positions it may well be that they can qualify for some assignments.

Supplementary Community Resources

Training in specific job skills is only part of vocational preparation. For retarded adults coming out of state hospitals and other institutions, there are many phases of community life on which they need help; and even young adults who have gone through the public schools and community training centers need assistance in establishing and maintaining their place in society.

The provision of suitable residential facilities for retarded people able to live and work in the community is treated elsewhere in this report (see pages 73-75), but it must be acknowledged here as an integral part of the continuum of services.

Suitable living arrangements imply proper, though not excessive, supervision of leisure-time activities. Experience around the United States has shown that moderately and even rather severely retarded persons may hold jobs satisfactorily; but when they fail it is usually because they are unable to handle their personal and social relationships, their leisure hours, the credit system, or other aspects of a complex modern society.⁴⁰ To avert this failure, the supervision of trained and sympathetic house-parents is valuable.

From time to time, the retarded, as other people, may have need for personal counseling in any of the myriad problems one may encounter. Family casework agencies, churches and other counseling resources should be open to the retarded, and wherever possible the counselor should be aware of the special difficulties of the retarded in the world of the "normal." As

suggested elsewhere in this report, the mentally retarded should have continuing access to the services available through the Regional Diagnostic and Counseling Center. (See Section IV.)

As with education and other basic community services, recreation should be available without discrimination against the retarded--but those who need specialized services should be able to find them.

Thus, many retarded children and adults can, if they are allowed, participate in existing services: use the parks, golf courses, tennis courts and swimming pools; attend day and over-night camps; utilize commercial resources such as movie theaters and bowling lanes; take part in Boy Scouts, Girl Scouts or Camp Fire Girls. The more severely retarded, and those with marked personality problems, may need rather more segregated services, which should be under skilled leadership.

Perhaps more than any other age group, the adolescent and young adult retarded need social programs scaled to their capabilities and interests. Activities such as dancing, picnics and group singing are appropriate and wholesome.

In other states it is being suggested that churches and synagogues make their resources available for recreation and other group activities involving the mentally retarded.⁴¹ This idea is sound, and the Study Commission commends it to the attention of religious groups in California.

Section VII.

HOSPITAL AND RESIDENTIAL CARE

In considering hospital and residential care, no less than community services, focus must be on the retarded individual. Institutionalization need not be a lifetime decision, but if it is to be truly part of a continuum of services, the principal criterion must be the individual's needs.

Accordingly, it seems appropriate to emphasize again the recommendations, already offered, on early and repeated evaluation of the retarded person:

Available to every family in California should be the services of a diagnostic clinic which will ascertain as early as possible the definitive diagnosis of mental retardation.

As part of a comprehensive program of family counseling, every community should offer an information and referral service on mental retardation.

There should be provision for systematic follow-up and reevaluation of retarded children in their preschool and later years.

Different retarded people have different needs; and any retarded person, at various stages of his life, may likewise have different needs.

For part or all of his life, a retarded individual may need to be in a hospital or residential setting for the care and specialized services it offers. This may be something as brief, specialized and intensive as a diagnostic workup which may take a few days or weeks. At the other extreme would be lifetime care for a severely retarded and physically handicapped individual who needs regular medical and nursing attention. In between are residential schools, temporary respite homes for relief of parents, vocational evaluation and training centers, psychiatric hospitals and sheltered homes for the protection of adolescent retarded girls.

Each offers a different service and each requires a different type of staff and a different physical plant, designed for the program it offers. In every residential facility for the retarded, there should be an atmosphere of hope and the pervading concept of rehabilitation.

Even in the institutions for the grossly handicapped, there can be continuing effort to encourage self-development. Retarded children who are thought of as "crib cases" will in all likelihood remain crib cases for the rest of their lives. But if they receive individual attention, some of them may in time be able to crawl on the floor, or to grasp a spoon to feed themselves. This level of self-help, however low, may represent the individual's ultimate potential--and every one should have the help and encouragement to develop to the limits of his capability.

The Study Commission endorses the principles expressed by the Colorado Division of Mental Retardation:

The mentally retarded differ in degree, not in kind, from other human beings. Retarded people experience hopes and fears, love and hate; can be happy or sad, healthy or sick, satisfied or lonely, the same as everyone else.

No one should enter an institution who can be cared for in the community; no one should remain who can adjust outside.

An institution caring for the mentally retarded should create an "inside" society which differs from the "outside" society only when institutional demands require it. A residential facility should be as much like the community as possible.⁴²

Today in California there is only one type of public institution for the mentally retarded: the state hospital. The 13,000 retarded persons in the "hospitals" include children who attend school, able-bodied adults who work in the wards and on the grounds, and elderly people virtually indistinguishable in disability from the senile patients in mental hospitals. Many are there because, years ago, their own homes were not able to care for them, or neighbors would not stand for their "different" behavior. Clearly, such people do not require hospital care merely because of their retardation; yet they are in state hospitals because there was no alternative service to meet their needs. The Department of Mental Hygiene has estimated that one out of three (33 percent) of the "patients" in the state hospitals and more than half (53 percent) of those on the preadmission list could be better served elsewhere if appropriate facilities or programs were available.⁴³ They are receiving inappropriate services for their needs.

Hospital Care

The term "hospitalization" is used in this report in a narrower sense than has been customary in California. By "persons needing hospitalization," the Study Commission means patients with medical, surgical or

psychiatric problems of such scope or intensity as to require care in a licensed hospital, with nursing and medical care prescribed by the patient's physician and usually requiring considerable professional nursing care.

On the basis of available information, it is difficult to project with accuracy the need for hospitals for the retarded in the decade ahead. Accepting the forecast of 20,000,000 population for California by 1970, and using the prevalence figures now available, the Study Commission believes it is necessary to plan for 13,200 beds (with a margin of error of 1,000) by 1970. Of the 13,000 beds now in use for the retarded, the Commission recommends that those at Patton State Hospital and DeWitt State Hospital be abandoned by 1970. This leaves an unmet need, by the end of the decade, of 4,150 hospital beds. At this time it is advisable to safeguard the estimate with a margin of error of 1,000, but reevaluation at periodic intervals of not more than one year will make it possible to reach greater precision.

The beds need not all be at state hospitals; in fact, the Study Commission recommends that a diversity of auspices be encouraged. Among these may be county or municipal governmental units, local pediatric or general hospitals, or nursing homes susceptible of conversion from their present programs. In all these alternatives, the State of California should assume responsibility for financial assistance and also for setting and enforcing standards of care. Ultimately, it is the responsibility of the State to see that facilities are available as needed, and if local government or community initiative does not meet the needs, there must be additional State initiative.

For any hospital serving mentally retarded patients, the Study Commission proposes these criteria:

New hospitals should have a capacity of 500 beds or less. No hospital for the retarded should contain more than 1,000 beds.

After much effort and thought, nationally recognized authorities have presented, through the American Association on Mental Deficiency, a formulation of "Standards for State Residential Institutions for the Mentally Retarded."⁴⁴ These seem eminently appropriate to California, and the Study Commission recommends that this publication, especially Sections III, IV and V, be the minimum standard for new hospitals. (These sections are reproduced as Appendix F to this report.)

Hospitals should be located within population centers throughout the State in a ratio approaching the population ratio. No hospital should be more than two hours' driving time from the

home of the retarded person. Each hospital should be used in connection with a diagnostic center, and day care and short-term services can be provided by the hospital for community-based programs.

As nearly as possible, all hospitals should be operated in conjunction with institutions of higher learning. The institutions of higher learning can be oriented toward any one of the related disciplines, and the hospitals should be collectively planned to take advantage of the training centers for all of the related disciplines including medicine, nursing, psychology, education and social work. There are several reasons for this recommendation: the hospitals can be a major teaching resource; they provide a valuable collection of case material; their proximity will encourage institutions of higher learning (including junior colleges) to take more interest in mental retardation; the availability of educational institutions, in turn, should stimulate programs of in-service training at the hospitals.

Residential Care

Other than hospitals, there should be a variety of residential facilities to serve the diverse needs of the retarded children and adults.

For example:

For children who can benefit from public schools and other community resources, but who cannot live with their own families, foster homes should be provided.

If a child lives too far from special education services suited to his needs, boarding home arrangements should be made for the five days he attends school each week.

For young adults able to engage in supervised work, community living arrangements may be appropriate.

For older retarded persons, community boarding homes and nursing homes should be available.

To the extent that such living facilities are not available, the retarded may be forced to enter or return to state institutions. The existence of suitable living facilities within the community for retarded persons of each

age level, and for all but the most severely handicapped, would reflect a concern with these people as individuals and would make it possible for them to enter into community life insofar as they are able. It would also facilitate normal family and neighborly relationships, which are harder to achieve in a large institution.

Another possible variant is the regional residential center, as developed by the state of Connecticut.⁴⁵ Legislators, public administrators, parents of the mentally retarded and community leaders alike appear impressed with the small center, close to the families of its retarded residents, and maintaining open-door relationships with nearby towns.⁴⁶ The regional center uses special classes and other services available in the nearby communities for its resident children; and in turn it provides the specialized services of its professional staff to retarded children living at home.

For many retarded adults, a public residential facility is not necessary, and yet those who are financially in need are unable to use private services. The Aid to the Disabled (ATD) program provides residential care in foster or boarding home situations for needy mentally retarded adults, but the law now excludes residential care in group settings. It would be helpful to make the ATD program a resource for all needy mentally retarded adults, including those who can live more satisfactorily in group care other than foster family care. The program could be extended to children.

The county welfare department should be responsible for finding, licensing and supervising foster homes and other private residential facilities for retarded children and adults, and for placing the retarded individuals in these homes, in accordance with standards set by the Department of Social Welfare. In exercising its responsibility with regard to former residents of state hospitals, the welfare department should cooperate closely with the Bureau of Social Work of the Department of Mental Hygiene.

At this stage (1964), it is still not clear what types of physical facilities and what program services may be best for each retarded person needing residential care. Moreover, it is not yet possible to tell, even in broad statistical terms, what the need is for each type of facility. Program planning should therefore allow for--indeed, should encourage--experimentation with different types of care, organization and financing.

Because precise and reliable information on bed needs is not yet available, it is possible to plan at this stage only on the basis of known need--that is, identified cases plus anticipated population growth. It appears, then, that we will need to provide for 13,000 retarded individuals (in addition to those requiring hospital care, as indicated above) by 1970. Allowing for the normal vacancy rate, this would require 16,250 beds.

Statistical estimates available from nationally accepted sources suggest that the actual need by 1970 will be much greater, but no verifiable data now support this assertion for California. Nevertheless, it appears advisable to safeguard the estimate by a wide margin for error, at least 25 percent. On this assumption, the Study Commission proposes that planning envision a need, by 1970, of between 12,000 and 20,500 beds for retarded persons other than those requiring hospital care.

The Commission urges, however, that the assumptions, the facts and the conclusions be reviewed every year, in order to make more precise estimates based on a growing body of knowledge.

Section VIII.

LIFELONG GUARDIANSHIP

Because a common characteristic of most retarded persons is immature judgment, they need special protection in matters involving money and the law. Lifetime guardianship arrangements are often advisable, both as to the estate and person of the retarded individual. The family may make protective arrangements through such devices as a will, an insurance policy or a trust,⁴⁷ but even where the parents fail to do so, society has the responsibility to protect its weaker citizens.

The association for retarded children, the lodge or church to which the parents may belong, all are possible avenues of protection for the retarded person; and if they are willing, they can offer a continuity of personal interest and oversight after the parents are gone.

For many retarded persons there are no family resources and for others the family needs an organized service to which it may turn for carrying out lifetime plans. The Study Commission recommends the development of two approaches for such a service--one private, one public. For the first, under voluntary auspices, we are pleased to note that the California Council for Retarded Children has begun to explore the establishment of a retardate guardianship-trust program under its own auspices. This would seem to be a valuable service, as the experience in Massachusetts and Maryland has demonstrated in recent years.

Beyond the voluntary program which a membership organization may establish, however, the Commission believes there should be a public guardianship service, authorized by the Legislature and available to every California family with a retarded child.

There are already provisions in the law which are useful in some situations. Section 103.9 of the Welfare and Institutions Code places on the county counsel certain responsibilities for obtaining a guardian at the request of the county welfare department. Section 5175 of the Welfare and Institutions Code permits the creation by the Board of Supervisors of the office of public guardian. Singly or together, however, these sections do not bring about a service which is available to every retarded person who needs it, nor do the statutes provide for coordination of the services needed by each individual.

The Study Commission believes that public guardianship service should be available for every retarded person who needs it. In addition to the legal and fiscal protection which a guardian of the estate offers, there should be the continuing concern for the retarded person as an individual. (The state of Washington in its statutes uses the term "parental successor.")

These functions involve the knowledge and skill of several professions--legal, financial management, and social work. Therefore, the office must be staffed with personnel equipped in these disciplines or it must be authorized to contract for them. For mentally retarded persons, the greatest need on a continuing basis will be for someone equipped to carry out social management.

The service should be available to every retarded person. It should be directly accessible, on request of the parent or other responsible relative of the retarded individual. In Minnesota, guardianship as a matter of state policy is made the responsibility of the county welfare department.⁴⁸ In practice in California today, county probation departments often provide the service. Still another alternative would be to fix responsibility with the Regional Diagnostic and Counseling Centers recommended by the Study Commission (see Section IV). The Commission commends this subject for further study--and decision within the next year--by the Mental Retardation Program Board, for there is no more poignant or challenging question than the cry of the parent: "What will happen to my retarded child when I am no longer able to care for him?"

Section IX.

WHAT WILL IT COST? WHERE WILL THE MONEY COME FROM?

The diversity of needs of California's mentally retarded people, and the complexity of programs, require new and imaginative administrative mechanisms. The problems of State services cut across departments and indeed across whole agencies. The roles of the Federal, State and local governments are intertwined. In addition to public facilities and services there are private programs, some of them proprietary and some eleemosynary. The public and private sectors at times find themselves in competition with each other, providing for retarded persons with similar needs and yet operating at widely different cost levels.

To systematize the pattern, raise the quality of services and insure an orderly provision for the needs of each retarded person, will take years. The Study Commission believes that the ultimate pattern of services will be an amalgam of State and local, public and private--but by intelligent design, rather than by accident, as now. The Commission therefore proposes a long-range objective and indicates the transitional steps to reach it.

Because programs are for people, it is necessary first to focus on the retarded individual and his family. Respect for the dignity of the individual underlies the Commission's thinking. This leads to the principle of self-determination.

The Study Commission proposes that each retarded person and his family have the final choice as to type of care, within a broad range of suitability determined by a counselor who knows the existing resources and the individual's needs. The effectiveness of this method of free choice depends (a) on the availability of alternatives of comparable quality, and (b) on the provision of intensive counseling by skilled personnel, so that the choice may be made intelligently.

While the Commission hopes this recommendation may become fully effective by 1970, there must obviously be a period of transition. There can be no choice when meaningful alternatives are not available. Moreover, the availability of skilled counsel is crucially important, as the families of retarded people will need guidance. Finally, it will take time to put the administrative and fiscal machinery in gear so that the new approach to eligibility and self-determination may become effective.

At the present time eligibility standards are so vague and so flexible that they often fail to provide meaningful criteria. The eligibility standards of various agencies should be made uniform, so that a family may select the appropriate service for its retarded member without the obstacle of having to re-qualify. Uniformity will provide for easy transfer from one service to another. The Regional Diagnostic and Counseling Center should have authority to determine eligibility for all services in accordance with agreements made by the operators of programs.

Ultimately, the location, type and sponsorship of the residential services will be determined by the collective demand of the people who need them, and their families.

Admission to state hospitals and other residential facilities should be on the basis of voluntary application by the parents or guardian of the retarded person. Involuntary admission should be used only when the retarded person is a danger to himself or to others.

In cases where the retarded individual and his family are not able to make a choice among programs, consideration should be given to making him a ward of the Juvenile Court, regardless of his age. The Court would then act as the parent, making a choice of care from the viewpoint of a parent rather than as an agent of the State. When appropriate, the Court could make use of the public guardianship service as recommended in Section VIII of this report.

In addition to its value in guiding the individual to the best service for him, the formulation of appropriate eligibility standards will encourage development of new techniques for dealing with the retarded. That is to say, there may be services and patterns not yet devised, which would be more effective in meeting the needs of the retarded, their families and society.

To qualify for benefits under the State's program, the retarded person or his family will apply at a Regional Diagnostic and Counseling Center. An agreement would be signed accepting the terms on which the services are offered. With the help of the Center staff, a form would be completed which would inventory the financial resources available to help pay for the services needed. Among these could be the family's own contribution, based in part on the cost of service needed but principally on the family's income level; the school's average daily attendance (a. d. a.) payment; any pension, insurance or retirement funds which may be payable in behalf of the retarded person; and such public funds as may be applicable, including veteran's benefits, unemployment benefits, Aid to Families with Dependent Children, Aid to the Disabled and Old Age Survivors and Disability Insurance. Beyond these resources, the Regional Center would arrange for a direct contribution from the State, which the Study Commission recommends be \$100 for each retarded person.

Money available from these sources would be credited to the account of the individual. On appropriate authorization, it would then be disbursed as needed to purchase services for him.

At the time of application, presumably, the retarded person would need some services. These might include medical or dental care, home-maker visits to relieve his mother, special education or vocational training, and possibly residential care. Later, when his immediate needs have been met, the retarded individual might not require any services for years, or perhaps for the rest of his life. In such case, his status at the Regional Center would become inactive. If a personal emergency or other need should arise later on, the necessary information would be on record and the State's service programs would once again be available to him as before. At the time of application, or at any subsequent time, the retarded person's family could arrange for lifetime guardianship in his behalf; the Regional Center would accept responsibility; and the arrangement would become effective when the parents themselves are no longer able to care for their retarded child.

Costs

At present, reliable cost figures are difficult to obtain, because accounting systems vary and because there are sometimes hidden subsidies. For example, a private day care nursery, a church program and a parent-sponsored activity--all for retarded children and possibly of equal quality--will vary by substantial amounts in apparent unit cost, because the church is providing its facilities rent-free, and the parent organization is able to enlist extensive volunteer help. Again, the cost of residential care in a state hospital and in a private school may be quite different, either because of the ratio of staff to retarded persons or because of specialized and highly expensive services provided in one facility and not in the other.

According to the best information now available, operating costs for hospital care range as high as \$4,000 a year for a retarded person, yet some private operators claim they can provide comparable or superior service at a lower cost. Estimates for capital outlay average about \$15,000 a bed for hospitals and considerably less for nursing homes, boarding homes and dormitories.

Until systematic cost accounting methods have been in effect for some time, it is not feasible to estimate the cost per unit of service that each retarded person will need; nor, consequently, can there be a usable figure as to total cost to the State and local governments. With the plan for record keeping of retarded persons and garnering all available financial resources, as proposed in the preceding pages, it is possible to estimate the gross cost to the State.

Assuming that one out of four of California's mentally retarded population would be receiving active service through a Regional Center at any time, it would appear that 100,000 individuals would be eligible for State assistance by 1970. (See Table I, page 19.) If the State's minimum contribution is fixed at \$100 for each retarded person who registers, this would bring the total annual cost by 1970 to \$10,000,000.

To supplement the financial resources collected from all other sources, the State will have to make payments from the General Fund. In computing this amount, credit should be allowed for the basic contribution to the account of each retarded person who applies. It is impossible at this time to determine what the amount would be in 1970. The State now has a known annual expenditure of \$90,633,515. (See page 36 and Table IV, page 35.) This figure represents identified expenditures of six State departments, and reflects an uneven provision of services. For planning purposes the level of expenditure should be raised at the rate of 2 percent per year, over and above the rate attributable to the population increase, until 1970, at which time the level should increase in direct proportion to the population increase. The proposed figure, projected to 1970, assumes far more effective service to a much larger number of retarded persons.

Financing

As indicated above, part of the financing for the proposed programs will come from the retarded person, his family and resources available to him as an individual; and part in the form of a direct appropriation by the State. In addition to whatever resources the retarded person himself may have, the Study Commission believes it is appropriate for his parents to contribute to the cost of his support and care, to the same extent as they would if he were not retarded. The financial obligation of the parents should cease when the retarded person reaches age 21. The Commission subscribes to the principles and limitations on financial responsibility developed by the National Association for Retarded Children.⁴⁹

Other fiscal resources will be grants from Federal government and private foundations, subsidies for approved programs by local governmental units, and contributions through private agencies and organizations.

Capital expenditures may be financed from Federal grants, FHA loans, private grants, local appropriations, and bond issues.

Any operating agency--State or local, public or private--which undertakes to provide a service to the mentally retarded and which meets the established standards, should be entitled to charge at a rate approved in advance.

Programs which do not provide direct services to mentally retarded individuals should nevertheless be entitled to subsidization on the basis of priorities determined by the Mental Retardation Program Board (see below).

Administration: Principles

To put into effect the program recommendations offered in this report, the Study Commission on Mental Retardation proposes the following principles for effective administration:

1. That the State's plan for meeting the needs of the mentally retarded permit and encourage self-determination.
2. That provision be made for uniform eligibility standards.
3. That the administrative pattern should foster the rendering of generic services to the mentally retarded by whatever agencies render such services to the general public.
4. That any plan adopted work toward the objectives of effective operational coordination among agencies both in program and fiscal planning.
5. That the cost analysis for programs serving the mentally retarded be conducted in such a way that meaningful cost comparisons may be made among programs under different auspices. It should ultimately be possible to obtain reliable figures as to cost per unit of service.
6. That the administrative machinery should encourage combination of resources from State, local and voluntary agencies, rather than establishment of rigid jurisdictional lines.
7. That any administrative mechanism which is evolved should be designed to utilize Federal, local and private funds insofar as possible.
8. That maximum flexibility be allowed for future developments, to take advantage of new concepts of program and procedure.

Administrative Mechanism: The Board and the Contract

As already indicated, the change to a new administrative pattern will not happen immediately but requires a transition period of several years. By 1970, however, the Study Commission believes it is possible to have in effect a mechanism and procedures which will insure more effective service to the mentally retarded and more efficient use of public funds.

The Commission recommends the creation of a Mental Retardation Program Board, to be appointed by the Governor and to function in the executive branch of State government. In establishing the Board, the Legislature should specify the members, including persons from all the State departments having responsibility for services to the retarded (the Departments of Education, Employment, Mental Hygiene, Public Health, Rehabilitation, Social Welfare and Youth Authority), local government units, representatives of voluntary organizations, and the "consumers" of services. The members should not exceed 15 at the outset. The Board should have power to employ an executive secretary and supporting clerical staff, but it will not operate any service programs.

The Mental Retardation Program Board will serve as a contractor in purchasing services for mentally retarded persons through those programs not assigned to a particular operating agency. The Board will have fiscal responsibilities and have the power to assign and reassign programs as part of a continuous planning process.

As a contractor, the Board will have power to enter into contracts for the provision of services to mentally retarded persons. The contractual arrangements may be with either public or private service agencies and at either the State or local level.

In making program assignments and reassignments the Board will have the power to determine the agency which must accept prime responsibility for the provision of a particular service. This responsibility can be discharged by the agency directly or by purchasing the service from another public or private agency.

Services will be paid for by the inventory of credits from the retarded individual, the State and all other available resources. The Regional Diagnostic and Counseling Centers will inventory the financial resources available to the retarded individual. Fiscal resources will be assigned on a fee-for-service basis. To the extent that additional resources are required, the Board and the agencies will receive funds directly by Legislative appropriation.

Another major function of the Mental Retardation Program Board will be to require standards of service. The Board will delegate the standard-setting responsibility to the agency assigned the service in most cases. In some areas of service, the Board will use recognized authorities, such as the American Hospital Association. In still others, the Board may find it necessary to purchase standard-setting services especially applicable to the programs of the contractors. The Board will require inspection and review procedures to enforce the standards. Further, the Board will provide, in

accordance with the terms of its contracts, consultant service to the operating agencies, to achieve continuing evaluation and improvement of their services.

To coordinate existing services and stimulate the development of new programs to meet discerned needs, the Board will develop and annually revise and publish a coordinated plan. It will recommend to the Governor and the Legislature needed changes in the statutes, modifications in existing departmental programs and appropriations. In this capacity, it will review budget proposals from the State departments. The Board will also arrange for pre-service and in-service training of State personnel for more effective work with the mentally retarded, and will stimulate the institutions of higher education to develop professional training curricula.

Because the Mental Retardation Program Board will not operate programs directly, its own budget can be quite small. Beyond the cost of programs for which it will serve as general contractor, the Board should be able to pay its own expenses--including Board meetings, staff and overhead--with an appropriation of \$100,000 a year.

In addition to its functions at the State level, the Mental Retardation Program Board should have the responsibility to encourage and stimulate comprehensive community planning to serve the mentally retarded and their families, and to set minimum requirements for such planning. As previously indicated (see page 51), each community should develop the mental retardation planning machinery appropriate to its needs. The State Mental Retardation Program Board should then have power to contract with the community planning agency for the provision of local services to the mentally retarded or to arrange for contracts with the departments having responsibility for operating programs.

Specific Recommendations for 1965-66

Within the framework set by the foregoing principles, and to move toward the administrative objectives described, the Study Commission offers the following recommendations for action by the Legislature at the 1965 session:

1. Continue in their present form existing programs administered by State and local agencies, including those programs already planned for the next biennium.
2. Establish a Mental Retardation Program Board, and empower it to employ an executive secretary.

3. Appropriate \$2,000,000, in addition to the funds currently appropriated for the retarded from the General Fund, to be spent at the discretion of the Board. Purpose of this provision is to permit the Board to contract with any entity wanting to provide services for the retarded (including a community mental retardation planning agency), preferably at a rate per unit of service.

4. Vest all agencies with authority to serve as contractors for services for retarded persons. Services should be bought and sold by agencies within both the private and public sector. This will facilitate arrangements with private operators of institutions for the mentally retarded, as recommended by the Assembly Subcommittee on Mental Health Services. The Commission wishes to encourage such arrangements where appropriate.

5. Vest the Board by law with authority to assign and reassign responsibility for the operation of programs to service agencies.

6. Assign initial responsibility for programs to the retarded in accordance with the following schedule:

All existing programs to be operated by agencies in accordance with existing requirements.

All programs recommended in this report to be operated by the agencies as designated.

7. Direct the Board to review budget proposals for mental retardation programs of the State departments conducting such programs, and make budgetary recommendations to the respective departments and to the Governor. Also direct the Board to develop and annually revise and publish a coordinated plan for the State government to provide services to the retarded.

8. Amend Section 6871, Education Code to cover mentally retarded children. The law now provides that a school district may pay the parent or guardian of a physically handicapped child the cost of tuition if the district is not providing suitable special education.

For the consideration of Congress, the Study Commission recommends an amendment to the Social Security Act with respect to the provision for aid to the totally and permanently disabled. (See also the change in terminology recommended at page 31.) As the law is now interpreted by the U. S. Department of Health, Education, and Welfare, it precludes the payment of Federally-assisted ATD funds to mentally retarded persons residing in private institutions. If the law were amended to permit such payments, there could be greater flexibility of service and program planning for the retarded in California.

Section X.

ENLARGING OUR KNOWLEDGE

"It is now possible to attack the causes and prevention, as well as the treatment, of mental retardation. This will require new breakthroughs, but it will pay enormous dividends in knowledge about ourselves, for the functions of the brain represent an almost completely uncharted frontier. The basic research entailed in such an effort will probe the essence of human development, and its results may far exceed its objectives." So said President Kennedy, when he announced establishment of the President's Panel on Mental Retardation.⁵⁰

Continuing research--both basic and applied--is crucial to prevent retardation. It also will produce new knowledge usable in amelioration and more effective treatment of the mentally retarded.

The President's Panel recommended that high priority be given to developing research centers devoted to the study of mental retardation at strategically located universities and at institutions for the retarded. California is in a particularly advantageous position to develop such research centers: at its state universities are now located institutes for the study of psychiatric and neurological abnormalities, and an Institute of Developmental Biology is being planned at the University of California, San Francisco. Moreover, state hospitals caring for the mentally retarded, principally Pacific and Sonoma State Hospitals, now have or are developing research facilities.

There is a vital need to intensify basic research into the causes of mental retardation, including prenatal influences, biological processes, transmission genetics, cytogenetics, neurochemistry and allied fields.⁵¹ Causation research requires an interdisciplinary team, including geneticists, physiologists, biochemists, embryologists, obstetricians, pediatricians, pathologists, neurologists and psychologists. In the monumental study of research, Mental Subnormality: Biological, Psychological, and Cultural Factors, Dr. Richard L. Masland observed, "There are few areas in medicine to which a wider range of interests are applicable and few fields in which the application of presently available techniques offers more hopes for productive discovery."⁵² Dr. Masland recommended "undertakings through which the problem of the mentally retarded is brought within the purview of a multi-disciplinary group, whose interests encompass a wide range of approaches to the study of human disease."⁵³

Basic research is effective in a university setting because there is opportunity for personnel from many disciplines to work closely together. At state hospitals and other residential centers for the mentally retarded, research can draw on a large sample of cases. Programs of research are most successful when these two assets are combined; that is, when the university draws on the hospital and residential center for case material and the opportunity for continuous observation, and when the state hospital utilizes the professional consultative services of the university.

Basic epidemiological research can be conducted most effectively by multidisciplinary teams based in agencies that have access to the individuals to be studied. Much research of this type will involve populations outside the institutions.

Research in the behavioral sciences is likewise essential to the enhancement of knowledge about mental retardation. The Study Commission has already noted the substantial proportion of the mentally retarded population whose etiology appears to be psychological, social and cultural. (See page 20 and the recommendations on prevention, pages 43-44.) Beyond nutrition and other considerations of medical and physical care, the poor performance of many children called "culturally deprived" has been attributed to three principal influences upon their development: a lack of motivation towards achievement and towards high performance; a home environment that does not develop the modes of thinking and perceiving common to the more favored child; a structure which is emotionally crippling to the child.⁵⁴ Currently available data clearly indicate that the incidence of mental retardation is higher in slum areas, chronically depressed areas and among individuals in low income brackets.

Here is a situation which calls for psychological, sociological and educational research. The studies must be long-term and multivariable. Both basic and applied research should be conducted in an interdisciplinary manner to isolate those factors which contribute to the majority of mentally retarded cases where no physical abnormality is apparent.⁵⁵

The consequences of poverty should receive early and urgent attention. Governor Brown has characterized this contemporary social problem as "class poverty," as distinguished from the "mass poverty" of the depression era.⁵⁶ Studies should be initiated in California on the causes which contribute to poverty. If this social problem could be diminished to any degree, its effect on the incidence of mental retardation would be immediate.

The education and rehabilitation of the mentally retarded individual, while recently expanded in California, still demands intensive development,

study and evaluation. There is need to explore the extent of present knowledge regarding the effectiveness of training and rehabilitation of the mentally retarded individual, with the view toward absorbing the maximum number as contributing, effective members of the community, rather than inmates of institutions.

Demonstration and evaluation are important elements of a total research program. The Study Commission notes that the Departments of Mental Hygiene and Social Welfare are currently engaged in a demonstration of services to the mentally retarded through local welfare departments. The Department of Public Health is also demonstrating new patterns of service, working through local health departments and other medical resources, such as the Childrens Hospital of Los Angeles and the Children's Hospital of the East Bay. Evaluation of these projects as they progress may disclose new and effective approaches to the provision of direct services close to home.

Experimental research findings should be tested in service agencies before being given widespread application. In some instances, dramatic research findings are accepted too promptly and applied without sufficient testing. In California, for a number of years, there have been limited local developmental testing clinics in operation, most of them affiliated with medical schools and many operating in local health departments. This has been particularly true in the southern part of the State.⁵⁷ This procedure should be adopted by children's hospitals and other health centers throughout California, particularly in association with university medical centers, so that there may be carefully controlled demonstrations of diagnostic and treatment programs.

Existing programs for the mentally retarded should be evaluated, and the design of new programs should include procedures for their evaluation. Furthermore, careful scrutiny is needed of currently prescribed treatment methods for known causes of mental retardation.

The Study Commission notes with approval that the Department of Public Health has recently established a Hereditary Defects Unit to explore genetic causation of congenital malformations, mental retardation and other conditions. Registries of genetically-produced disabilities, including phenylketonuria, will also be established.

With proper analysis and coordination, information already available can discover families more likely to have retarded children. Similar techniques can also suggest newborn babies and infants who are likely to develop mental retardation and for whom prompt preventive measures can ameliorate an otherwise potentially damaging condition. Information based on

such continuing efforts can give more precision to statistics on incidence and prevalence of mental retardation and can help evaluate the impact of prevention programs.

The Study Commission believes the Legislature should give such programs and planning full encouragement and necessary financing. As screening, registration and surveillance programs are developed, the Department of Public Health should have responsibility for bringing this information together with other available data on the incidence and prevalence of mental retardation in California's population.

Child Study Centers for the Retarded

A Child Study Center for the Retarded, conducted in cooperation with and under the auspices of one or more universities or state colleges, should be established. Such centers should be staffed with fully qualified psychological, medical, nursing, social work and educational personnel to develop a coordinated demonstration service for the mentally retarded. This facility would not only offer tangible therapeutic services for the retarded but would also serve as a superior training resource for personnel needed to guide retarded children. Here, action research on teaching methods can be realized in a setting where retarded children are being guided to use their full capabilities.

In addition to the research value, a Child Study Center for the Retarded would have great usefulness in training teachers and other professional persons. This is another reason each Center should be close to and associated with an institution of higher education.

State Responsibility for Research

To serve the needs of the mentally retarded, and exact the greatest service from our existing research capabilities, the Study Commission recommends:

That the State of California maintain adequate, fundamental budgetary support of the research programs in the biological and social sciences in California's many institutions of higher learning. It is important not to overlook the valuable contributions to be made by private institutions, both universities and hospitals and by other community resources.

That the State of California continue and financially support full-time research facilities and positions in the major state institutions which have a responsibility for the mentally retarded and within the separate agencies of State government actively concerned with mental retardation.

That the State of California provide machinery and support positions in the field of "community action" research related to public health and social welfare problems of the retarded. To accomplish this objective, it may be necessary to establish a State-funded, grant-in-aid program to selected municipal agencies.

That the proposed Mental Retardation Program Board take responsibility for insuring the coordination of research in California, relating it to research efforts elsewhere in the United States and throughout the world, and arranging adequate financial support. It is further recommended that the Board develop a Research Advisory Council, to include representatives of institutions now engaged in mental retardation research, plus other experts in the biological and social sciences.

For the consideration of the Legislature and the proposed Mental Retardation Program Board, the Study Commission expresses its conviction that the State should make available sufficient funds to develop and maintain creative research efforts at the universities in California and institutions and centers serving the mentally retarded. This is important not only for the intrinsic value of the research and its practical applications in mental retardation, but also in order to attract and keep for California a reservoir of scientific talent.

To the greatest extent possible, full utilization of Federal and private foundation funds should be made, including appropriate funds available from the U. S. Department of Health, Education, and Welfare. There is, however, an increasing tendency to rely heavily on national funds or foundation grants without recognizing certain personnel problems arising out of such financial arrangements. Research scientists supported by such sources of funds have to live from grant to grant and do not receive university tenure or security. A small-grant mechanism would help to subsidize the interval between project grants. Grants of the magnitude of \$10,000 could be established to initiate exploratory studies, so often essential to the development of major research efforts which would then qualify for project grant funds. It is essential that a small-grant mechanism be made very flexible and administratively simple, for its prime purpose is to remedy the growing inflexibility and delay in the present Federal programs.

Total cost of the small-grant program will be \$250,000 a year.

Section XI.

THE SKILLED PEOPLE WHO WILL DO THE JOB

From the beginning of its work, the Study Commission was aware of the gross shortage of inadequately trained personnel in all fields of service to the mentally retarded and their families. In fact, the President's Panel on Mental Retardation had, a year earlier, devoted a considerable part of its report to the problem and had offered useful recommendations for national action.⁵⁸ Among these were scholarships, fellowships, increasing the capacity of professional schools through new construction and other means, and encouragement of careers in research.

The Study Commission conducted a statewide, multi-disciplinary inquiry into manpower problems, with particular emphasis on seven fields serving the retarded in California: educational services, health services, psychological services, vocational rehabilitation and placement, social services, day care and residential services, and recreational programs. These services embraced a variety of professional fields, and in each one there was reported a significant shortage.

In some professional fields the shortage is precise and measurable, in others not. Thus, the fact that 48,388 children were enrolled in special classes for "educable" mentally retarded and 4,207 in classes for the "trainable" in the school year 1963-64 was a clear measure of the need for teachers. On the basis of anticipated population growth and expansion of services under existing law, the need for additional teachers in special education may be forecast with some accuracy to the school year 1973-74.⁵⁹

In such professional fields as psychology and social work, on the other hand, the insufficiency of personnel is not so precisely measurable. It is possible to apply national standards and ratios to California, but the shortage is not as obvious because the human need is hidden. In the health professions the inadequacies are even less clear because of the numerous medical and allied specialties. Even if there were enough physicians, there might not be enough pediatricians, child psychiatrists or pediatric neurologists, for example.

Nevertheless, it is possible to enumerate the professions in which there are shortages of trained personnel and to forecast that at the present rate of recruitment the situation will grow worse.

In special education, the need is not only for teachers but also for teacher assistants, school psychologists, curriculum specialists and supervisors. In nursing, as in some other fields, the insufficiency of trained persons is aggravated by the high turnover, not only through retirement but through frequent job changes. In vocational rehabilitation, plans for development of new and needed services will create additional shortages of qualified practitioners. (The Commission has been informed, however, that when rehabilitation positions are created, Federal funds are available to help train personnel.)

The need for additional personnel to serve the mentally retarded is forcefully apparent today because of the current public concern with retardation. Indeed, the recommendations of the Study Commission, throughout this report, will obviously call for more rather than fewer qualified professionals. Nevertheless, the fact is that the shortage is not limited and specialized but general and pervasive. There are not, in the United States or in California, enough physicians, enough dentists, enough nurses, enough psychologists, enough social workers, enough teachers, enough rehabilitation specialists. . .and if it were possible to train enough to meet only the needs of the retarded there is no assurance the persons so trained would continue to work with the retarded. On the other hand, it is not enough merely to train people for their respective professions; there must be active recruitment and specialized training for the particular problems posed by retardation.

If the recommendations of the President's Panel and of the Study Commission are followed, they will at best be part of a larger effort at recruitment, training and retention in the professions. Once this is done, however, it will solve the manpower problems not only for the retarded but for other handicapped children and adults as well.

Two years ago, the Welfare Study Commission gave particular attention to the shortage of trained and qualified social workers.⁶⁰ Among the recommendations for more effective use of existing staff were improvement of salary levels and grade differentials, establishment of manageable caseloads, adequate supervision and the use of specialized consultants. Recommendations were also offered on in-service training, professional training and recruitment. The Study Commission on Mental Retardation endorses the recommendations of the Welfare Study Commission as having substantial pertinence to the provision of high-quality public welfare services to the mentally retarded and their families. Indeed, a number of the proposals are easily adaptable to the recruitment, training and retention of professional personnel in other fields of service to the retarded.

Elsewhere in this report, the Study Commission proposes the establishment of Child Study Centers for the Retarded. (See page 89.) The recommendation is offered there in the context of research, but clearly there would be an important component of professional training for teachers and other professional personnel.

Summarily, it is possible to list several avenues of activity to bring the supply of properly trained personnel into closer conformity with the anticipated need:

1. Step up general recruitment into and training for the various professions, with as much emphasis as possible on the rewards and satisfactions of working with the mentally retarded. This effort must start in the high school years, but it can also be effective at the college and even graduate levels. The responsibility is shared by educational counselors, professional organizations, and associations for retarded children, as well as the government and voluntary agencies that require the professional personnel.

2. Promote interest in working specifically with the retarded. In addition to recruiting into the field, this calls for keeping people at work with the retarded, and bringing back those who have retired or moved to other specialties. Specific measures should include:

An increase in the support for research programs into both the biological-physical aspects of retardation and in the area of psycho-social adaptation and learning. Such an increase in basic support for research would attract the interest of investigators and research workers presently engaged in other fields but having an important contribution to make through the discovery of new knowledge which will basically affect manpower needs and requirements.

Action by pertinent licensing bodies to require knowledge of mental retardation in their examinations for professionals.

Increased attention to the mental retardation service field by professional societies in the various disciplines.

3. Expand the present professional schools, create new ones as needed, and encourage those now providing professional training to enlarge their offerings in mental retardation. The opening of three new graduate schools of social work (at Fresno, Sacramento and San Diego State Colleges) in the fall of 1964 was a large step in the right direction. Specifically, there should be:

Increased emphasis on principles and problems of work with the mentally retarded in the curricula of all the types of professional schools and undergraduate departments that train such personnel.

Expansion of Extension and Continuing Education programs relating to retardation by universities and colleges. Emphasis on short-term "refresher" courses and special training institutes for already employed professionals.

Increased use of agencies working with the retarded for field placement of students in social work, clinical psychology, and other disciplines as well as in teacher training programs.

Professional training, it should be added here, ought to be on the basis of inter-disciplinary teamwork and respect. Those engaged in professional activity today are increasingly aware of their interdependence; future professional practice will be easier if the training starts with the assumption that this is the pattern, and if the training itself is in a team setting.

To reach the goal of adequate sophistication regarding mental retardation on the part of the general medical practitioner, university training programs must be expanded in all disciplines, medical and paramedical. Federal training funds should be made available to facilitate this. (In an informal address to the Study Commission at its meeting January 17, 1964, Dr. Samuel A. Kirk, director of the Division of Handicapped Children and Youth in the U. S. Office of Education, suggested that California colleges could obtain Federal stimulation grants for the training of teachers of pre-school retarded children.) Arrangement should also be made for some preferential provision of Federal funds for the construction of facilities to serve as teaching centers in mental retardation.

4. Expand and improve in-service training programs, and inaugurate one wherever there is a service program under competent professional leadership. The National Institute of Mental Health offers funds to support in-service training programs for personnel at state institutions for the mentally retarded. The Departments of Social Welfare and Mental Hygiene, among others, are currently engaged in such training efforts. It is possible to develop in-service training even in a small diagnostic clinic, sheltered workshop or private residential facility. Universities and colleges can help by providing in-service training aids, especially to the public departments engaged in the development and provision of programs for the retarded.

5. Redefine the tasks, so that some portion of the work, requiring less than full professional preparation, may be done by other persons. There are already teachers' aides, who may take attendance or collect milk money; nurses' aides, who perform routine sub-professional chores in hospitals. With imagination, the professional core of each position can be defined, and the lower-skill activities assigned to others. This will have the incidental but valuable effect of making the professional job itself more attractive to people considering entering the field.

An allied recommendation is that in such categories as social worker and clinical psychologist, which are currently in short supply, there be planned experimentation with alternate and shorter means of providing basic professional preparation, to be followed by internships in agencies rendering service to the retarded. It seems particularly possible and appropriate to develop such clinical internships in the state hospitals and clinics for the retarded.

6. Use volunteers. Retired professional people may be willing to refurbish and utilize their skills as volunteers, whereas they would not consider return to full-time or even part-time employment. Moreover, some of the jobs can be well performed by intelligent though untrained volunteers, just as some can be handled by sub-professional staff people.⁶¹ Volunteer work is no substitute for proper professional service, but if portions of the service would otherwise go undone for lack of fully qualified personnel, there are ways in which volunteers can relieve the shortage, by working under proper supervision.

Beyond and in addition to all other recommendations, special emphasis must be given to financial and to status considerations. If the rate of compensation were raised to a level comparable with what the same intelligence and skills might command in other fields, recruitment and retention of personnel would be less difficult in the helping professions.

Of more immediate value, and perhaps more easily attainable, are financial inducements to students and young practitioners. Scholarships, fellowships and study grants are not highly expensive, and a relatively few dollars properly spent at the right time may steer or keep a competent person in the field of service to the retarded.

In the 1963 session, the Legislature enacted Assembly Bill 813, appropriating \$60,000 to the Department of Education to pay summer school expenses for teachers seeking to qualify for credentials in special education. In preparation for summer study during 1964, 355 teachers were approved for grants.⁶² The program has already proved itself successful and valuable, and the Study Commission recommends that the act be extended and the appropriation increased to \$150,000 for each of the 1965 and 1966 summer sessions.

Scholarships and supporting grants should also be available for regular term students working toward preparation for careers in special education. The Department of Education's Bureau of Special Education has estimated 500 persons a year, or one-third of the needed total, will require scholarship assistance to pursue their studies. To provide the assistance would require \$800,000 a year in grants to the students and an additional \$1,000,000 for supporting grants to the colleges providing the training.

Respect--from the general public and from one's professional colleagues--is another meaningful inducement to enter or to stay in work with the retarded. Full preparation for specialized work with the mentally retarded requires more effort than some of the other professional choices open to the physician, the dentist, the teacher, the social worker, the psychologist, or the nurse; and public acceptance of the value of the work is a persuasive recruiting device.

Mention has already been made of sub-professional personnel. In these areas, too, there are staff shortages. Psychiatric technicians employed at the state hospitals, day care workers in nurseries for the retarded, and similar non-professional persons are in short supply, and there is high turnover. There are many aspects to this problem too: geographical remoteness of many of the jobs, low compensation, lack of public recognition of the value of the tasks. When the other recommendations of the Study Commission are accepted, California will be on the way to solving this problem as well.

As a sidelight, considering the separate problem of employment of the retarded, thought should be given to the possibility of using mildly retarded adults to perform some of the unskilled tasks associated with caring for retarded children. Throughout the United States (including California), retarded persons make a significant contribution to the effective running of the state institutions, by the many jobs they do. These have genuine economic value and deserve compensation. As an example from community programming, at the Pilot Child Care Center for Mentally Retarded and Physically Handicapped Children in Stockton, several retarded teen-agers come each day to help care for the more severely handicapped youngsters, under the supervision of a trained teacher and other adults. For this they receive almost nominal compensation, but they enjoy the work, they feel useful, and they do indeed perform a service.

Section XII.

A ROLE FOR CALIFORNIA'S HIGHER EDUCATION SYSTEM

At several points throughout this report, the Study Commission has suggested ways by which California's institutions of higher education might augment and strengthen services for the mentally retarded. There are important roles for the University of California, the State Colleges and the junior colleges. The Commission recommends that the Coordinating Council for Higher Education consider how each of the systems might make its contribution. Following are some of the major tasks:

Research

There are major advances in knowledge just ahead in the biomedical, genetic and behavioral sciences. The Federal government and private foundations have indicated they will help to finance both basic and applied research projects; and the Study Commission is suggesting a role for the State as well. It remains only for scientific investigators to develop creative ideas and for their sponsoring institutions to give encouragement.

Rich resources of case material and detailed records exist at the state hospitals. Other direct service agencies--day care, vocational training, private residential schools and others--will cooperate. The Regional Diagnostic and Counseling Centers recommended by the Study Commission will offer extensive opportunities for longitudinal study.

The results of scientific investigations should be shared promptly through publications, reports at professional gatherings and the other accepted means of dissemination of research findings.

(See Section X)

Preparation of Skilled Personnel

The universities and colleges are the principal hope for training of the professional people required to provide services for the mentally retarded and their families. Among the professions are medicine with its many specialties, nursing and the other paramedical professions, education, psychology, social work and administration.

There must be enlargement of present programs, both graduate and undergraduate, and the development of new offerings, for any hope of coping with the shortage of skilled manpower. Colleges offering courses in special education should maintain demonstration classes in conjunction with their professional programs. Graduate schools of social work should develop additional field-work placements to bring their students in contact with services for the mentally retarded.

To an increasing extent, it is desirable that students in the helping professions be trained as members of teams, for in the world of practice they will find themselves working with persons from other disciplines. The Child Study Centers for the Retarded, as recommended by the Study Commission (see page 89), will offer a major opportunity for both professional training and research.

Among the sub-professional occupations for which additional people should be trained are day care center supervisors, recreation directors and psychiatric technicians. The colleges should also cooperate to develop and help conduct in-service training programs at state hospitals and other program agencies for the mentally retarded.

Federal grants are available for training in the professions and occupations serving the retarded.

(See Section XI)

Adult Education and Community Development

Parents of retarded children want to know more about their youngsters' handicaps, but often they have no reliable and continuing source of information. A major educational service would be the organization of parent-education classes which can be brought to the home communities. General public education at the community level is also required to overcome ignorance and mistaken attitudes about the handicapped; among the mechanisms are institutes, conferences and publications.

The Study Commission was impressed with the effectiveness of University of California Extension in organizing and executing six regional workshops to obtain public reaction to the Commission's tentative conclusions and recommendations in the fall of 1964. Such educational and organizational skills should be available on a continuing basis.

A significant service to government is performed when the University and the State Colleges maintain close working relationships with departments of State government and with community agencies near each campus. The link

between the University and the Department of Mental Hygiene, through the Neuropsychiatric Institutes, is one outstanding example. Institutions of higher education can also perform a major service by encouraging their faculty members to take an active part in community organization efforts. Not only the mentally retarded, but all citizens of California, benefit from such activities.

(See Section V, especially pages 51-52, and Section XIII)

Internal Coordination

As concern for the mentally retarded develops in California's system of higher education, there comes a growing need for coordination at each institution and among the various campuses.

The Study Commission recommends that each president and chancellor consider the establishment of a faculty committee on human development, to interrelate the activities of different departments and disciplines.

Section XIII.

PUBLIC OPINION--A POWERFUL ALLY

Understanding and accepting public attitudes are essential to the success of any community program for the retarded; indeed, the whole concept of keeping the retarded close to home rather than placing them in remote institutions depends on community acceptance. Studies of public opinion in various parts of the United States disclose that there is still widespread ignorance concerning the true nature of mental retardation and the capabilities of the retarded.⁶³ In consequence, there is resistance to proposals which suggest that retarded persons have a place in the community, or indeed that they have any human dignity or value at all.

Public information efforts should be an integral part of the service program, as a responsibility of every agency concerned with the retarded.

With public understanding, these tasks become easier:

Keeping the retarded in the community, at home, in the neighborhood.

Acceptance of care for the retarded as a social responsibility, expressed in the development of more adequate special education, sheltered workshops and other community services as recommended by the Study Commission.

Acceptance of retarded individuals in the parks, recreation centers, churches.

Seeking of early diagnosis, counsel and treatment.

Relief of the centuries-old sense of guilt and shame. (The parent who learns today that his child is retarded was until yesterday a member of the "general public." If the public accepts retarded children, the new parent finds it easier to accept his own child.)

Willingness to accept guidance toward the appropriate service. (Part of an effective public information program would be the theme that sometimes handicapped children are best cared for in their own homes, but sometimes not. Thus, a parent would be encouraged to accept placement of her child in a foster home without feeling guilty at being unable to care for the child herself.)

Recruitment into the field of working with the mentally retarded--including high school and college students, professional people and other personnel.

Recruitment of volunteers.

Cooperation of employers and labor unions.

Encouragement of research.

Section XIV.

CONTINUOUS PLANNING, EVALUATION AND REVIEW

Planning for more than a decade ahead, even in the broadest outlines, is impractical; and the specifics must be subject to periodic review. In a state which is growing as rapidly as California, it is necessary to provide for continuous study of the needs and periodic revision of the plans.

In connection with grants for construction of facilities for the mentally retarded, the Federal government has stipulated a requirement that any state plan be reviewed at least once a year. Planning for construction to be effective, must be done in close coordination with program planning.

The administrative mechanism recommended by the Study Commission--the Mental Retardation Program Board--will provide for regular review of existing programs in relation to needs, and for continuous planning. The Commission has also recommended that the State Board set standards and stimulate the development of mental retardation planning machinery in the local communities (see page 51); the local planning organizations likewise will have an obligation to conduct continuing review and evaluation. Among the specific subjects for attention in the years immediately ahead, the Commission particularly notes:

1. Existing services, principally at the local level throughout California but also, to some extent, at the State level.
2. The incidence and prevalence of mental retardation in California. As already indicated, we are not satisfied with the amount or accuracy of current information. The study of Riverside will yield useful data, but additional research is necessary.
3. The number and kinds of beds needed in residential facilities other than state hospitals. The Commission is not at all content with the dependability of its statistical estimates on this point, and has so indicated by suggesting a large margin for error. (See page 75.) This margin must be reduced, for effective planning.
4. Architectural design. Physical plant must be related to program objectives, as suggested by the standards of the American Association on Mental Deficiency. (See page 72 and Appendix F.) It is shocking and dismayingly that even as the Study Commission pursued its work in 1964, there were being constructed in California "new" facilities for the mentally retarded which embodied outmoded and negative concepts.

5. Existing laws. A review of California statutes⁶⁴ discloses numerous provisions which discriminate against the mentally retarded, or which have a prejudicial effect when applied without special consideration for the limitations of retarded persons. In the interests of equitable treatment under the law, there should be a review and revision of the statutes.

6. Present and to-be-established services for the mentally retarded require continuing review and evaluation. This has been suggested in the Commission's discussion of research (Section X); it is necessary both to prevent the perpetuation of inadequate services and to make more widely available the knowledge which grows out of successful experience.

7. Sterilization. For the prevention of some types of retardation, and also for the protection of retarded individuals who may be able to live fairly normal lives in the community but who would be unable to handle family responsibilities, it has been suggested that the recourse of sterilization be considered. The Study Commission did not have sufficient information to make a judgment on this point but it recommends that there be careful study of the proposal, including examination of experience under present California statutes.

8. Guardianship. As indicated in Section VIII, the Study Commission is not satisfied with its own work on the subject of guardianship. This requires more intensive study, but it is a subject which should have prompt attention because it affects every family with a retarded child or adult.

9. A model for community self-study and organization of the local continuum of services. An increasing number of California communities and counties are engaged in self-examination of their programs for the mentally retarded, and it would be helpful if they could share their methods and in addition receive guidance from the State.

10. Public attitudes. The Commission has noted the importance of a favorable and understanding climate of public opinion. (See Section XIII.) In order to bring public attitudes in closer conformity with present-day information, it is important to know what those attitudes are. There is a role for opinion research, specific enough to differentiate among the many segments of the general public--parents, neighbors, professional people, civic leaders, businessmen, farmers, working people and others.

NOTES

1. Heber, Rick, "A Manual on Terminology and Classification in Mental Retardation," American Journal of Mental Deficiency, Monograph Supplement, Second Edition, 1961, p. 3.
2. President's Panel on Mental Retardation, A Proposed Program for National Action to Combat Mental Retardation, 1962, p. 1.
3. Heber, op.cit., p. 4.
4. Letter to the Study Commission on Mental Retardation, October 26, 1964.
5. Heber, Rick, "Modifications in the Manual on Terminology and Classification in Mental Retardation," American Journal of Mental Deficiency, January 1961, pp. 499-500.
6. Dybwad, Gunnar, Challenges in Mental Retardation, Columbia University Press, 1964, p. 235.
7. President's Panel on Mental Retardation, loc.cit.
8. In Fresno County, using the 3 percent value, the Community Council estimated 10,978 retarded persons. After exhaustive search of agency records, however, a survey found only 1,020 individuals. (Fresno Community Council, Report of Mental Retardation Project Committee, 1964, p. 21.) Even with the Study Commission's lower estimate of prevalence, there would appear to be a substantial number in Fresno County, as elsewhere, who are not receiving services they need.
9. Statements drawn from Jastak, Joseph F., MacPhee, Halsey M., and Whiteman, Martin, Mental Retardation: Its Nature and Incidence, University of Delaware Press, 1963.
10. Study Commission on Mental Retardation, Report of Survey by Committee on Existing Resources, Functions, and Coverage, June 1964. Copies of the 113-page committee report are available on request from the Commission.
11. Adapted from Table I in the committee report.
12. Table XII in the committee report.
13. Kennedy, John F., A National Plan to Combat Mental Retardation, 1961, p. 4.
14. President's Panel on Mental Retardation, op.cit., p. 6.
15. Proceedings, The White House Conference on Mental Retardation, 1963, especially "The Goal of Prevention," pp. 73-101 and 109-110.

16. State of California, Department of Public Health, Public Health Programs for the Mentally Retarded in California, March 1964, p. 14.
17. See Social Legislation Information Service, Washington Bulletin, May 25, 1964. Also Montgomery, Theodore A., Lewis, Arline, and Hammersly, Marjorie, "Maternal Deaths in California, 1957-1962," California Medicine, June 1964, pp. 412 ff.
18. U. S. Department of Health, Education, and Welfare, Welfare in Review, April 1964, pp. 10-11.
19. Washington Bulletin, op.cit., p. 261.
20. Report of the Senate Fact Finding Committee on Labor and Welfare: Aid to Needy Children Program, 1961, p. 48.
21. Dunn, Lloyd M., "A Sociological View on the Prevention of Mental Retardation," Proceedings, The White House Conference on Mental Retardation, 1963, pp. 103-108.
22. Assembly Subcommittee on Mental Health Services, A preliminary proposal to eliminate "waiting lists" for State Hospitals for the Mentally Retarded, June 1964, pp. 14-15.
23. President's Panel on Mental Retardation, op.cit., p. 92.
24. The Los Angeles Mental Retardation Joint Agencies Project, which was preparing its recommendations as the Commission report was being drafted, is expected to propose the establishment of five community mental retardation service centers in Los Angeles County alone.
25. California Medical Association, Statement Recommended by the Committee on Mental Health to the Council, August 8, 1964.
26. Klebanoff, Lewis B., "Facilities for the Mentally Retarded: Integrated or Separate but Equal?" American Journal of Public Health, February 1964, p. 248.
27. President's Panel on Mental Retardation, Report of the Mission to the Netherlands, July 1962, p. 75.
28. See Standifer, Frances R., "Parents Helping Parents," Mental Retardation, October 1964, pp. 304-307. Also Weingold, Joseph T., "Parents Counseling Other Parents," Children Limited, February 1963, p. 2.
29. A Position Statement by the Council of the American Psychiatric Association, December 15, 1963, p. 2.
30. Stevens, Harvey A., "The Importance of Coordination of Services for the Mentally Retarded," paper presented at annual conference of Central Coastal Region III, American Association on Mental Deficiency, Palo Alto, California, April 4, 1964, p. 6.

31. Report of the Joint Interim Committee of the California Legislature on the Education and Rehabilitation of Handicapped Children and Adults, January 1959, p. 128.
32. Ibid., p. 152.
33. State of California, Department of Education, "Enrollment in Special Training Classes for Educable Mentally Retarded Minors (Education Code Section 6902) in the Public Schools of California, Fall Semester, School Years 1948-49 to 1963-64," and "Enrollment and Number of Special Training Classes for Severely Mentally Retarded Minors (Education Code 6903) in the Public Schools of California, Fall Semester, School Years 1952-53 to 1963-64" (mimeographed).
34. National Rehabilitation Association, Policy as Related to Mental Retardation (mimeographed), 1964, p. 2.
35. President's Committee on Employment of the Handicapped, Guide to Job Placement of the Mentally Retarded, 1963, p. 6.
36. U. S. Department of Labor, Office of Manpower, Automation and Training, Manpower Research Bulletin Number 6, The Mentally Retarded: Their Special Training Needs, October 1964, p. 1.
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38. Alameda County School Department, Training the Custodian's Assistant, 1962.
39. Dybwad, op.cit., p. 89.
40. President's Panel on Mental Retardation, Report of the Task Force on Education and Rehabilitation, August 1962, pp. 60-61. See also 28-page section on rehabilitation of the mentally retarded in Journal of Rehabilitation, November-December 1962, especially Power, F.Ray, "Major Issues: A Plan of Action," p. 33.
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42. Colorado Department of Institutions, Division of Mental Retardation, "Policy Statement" (mimeographed), 1964.
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48. State of Minnesota, Manual of the Department of Public Welfare: Mental Deficiency and Epilepsy, 1959, pp. 5-9.
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53. Ibid., p. 26.
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55. See the recommendations for research on psychological and cultural problems (Chapter XIX) in Masland, Sarason and Gladwin, op.cit., pp. 392-400.
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59. Detailed information is contained in a report, "Manpower Problems and Services for the Mentally Retarded," prepared for the Commission.

60. State of California, Welfare Study Commission, Final Report, 1963, pp. 36-45. For more detailed observations and recommendations, see Part Two, Consultants' Reports, "Services, Staffing and Manpower for a Constructive Public Assistance Program in the State of California," pp. 134-139, 150-162.
61. For a discussion of tasks which volunteers can perform, see Rich, Thomas A., and Gilmore, Alden S., "Volunteer Work with the Retarded," Mental Retardation, August 1964, pp. 231-234. For a list of advantages to the state residential institution, see Hartford, Robert J., "A Volunteer Program in a State School for the Mentally Retarded: An Administrative Viewpoint," American Journal of Mental Deficiency, November 1960, pp. 318-321.
62. State of California, Department of Education, Special Education Newsletter, November 1964, p. 9.
63. A survey in Gainesville, Florida, is reported under the heading "Professional Sections," Mental Retardation, June 1964, p. 184. Studies in four communities of the State of Washington are reported in an unpublished paper by Justice, R. S., and Tjossem, T. D., "Community Acceptance of the Retarded Child." A survey of public information and attitudes regarding mental retardation in Minnesota, sponsored in 1962 by the Minnesota Association for Retarded Children and the Minnesota Department of Public Welfare, was published under the title "Public Impressions of the Mentally Retarded." See also Sandahl, Eric, "The Editor Talks Things Over," Children Limited, October 1959, p. 10.
64. A comprehensive investigation into the present statutes was conducted in 1964 under the auspices of the Study Commission on Mental Retardation. It has been published separately, under the title, Mental Retardation and the Law.

Appendix A.

THE LAW CREATING THE STUDY COMMISSION ON MENTAL RETARDATION

Assembly Bill No. 1193, 1963 session, as amended by Assembly Bill No. 52, 1964 session:

An act to amend Section 7600 of the Welfare and Institutions Code and Section 2 of Chapter 935 of the Statutes of 1963, relating to the Study Commission on Mental Retardation, making an appropriation, to take effect immediately.

The people of the State of California do enact as follows:

Section 1. Section 7600 of the Welfare and Institutions Code is amended to read:

7600. There is created in the state government the Study Commission on Mental Retardation. The commission shall be composed of 16 members to be appointed by the Governor and to serve at his pleasure.

Members shall be selected from the fields of medicine, education, law, public health and welfare. The commission shall be composed of the directors of the following state departments: Education, Mental Hygiene, Employment, Public Health, Rehabilitation, and Social Welfare, two county supervisors, two local mental health directors, and six persons representing the general public.

The Governor shall designate the chairman of the commission.

7601. Two Members of the Senate, appointed by the Senate Committee on Rules, and two Members of the Assembly, appointed by the Speaker, shall meet with, and participate in, the work of the commission to the extent that such participation is not incompatible with their positions as Members of the Legislature. The Members of the Legislature appointed to the commission shall serve at the pleasure of the appointing power. For the purposes of this chapter, such Members of the Legislature shall constitute a joint interim legislative committee on the subject of this chapter and shall have the powers and duties imposed on such committees by the Joint Rules of the Senate and Assembly.

7602. The members of the commission shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

7603. The Department of Mental Hygiene shall employ staff to assist the commission.

7604. The commission shall hold not less than four scheduled meetings each year. All meetings and hearings shall be open to the public.

7605. The chairman of the commission shall have the powers conferred upon heads of state departments by Section 11181 of the Government Code.

7606. The commission may employ and fix the compensation, in accordance with law, of an executive secretary and such other clerical and technical assistants as may be necessary.

7607. The commission shall study and make recommendations on the following:

(a) Planning and implementation of policies, procedures, programs, services and activities pertaining to identification, care, treatment, education and general rehabilitation of mentally retarded persons and research in the field of mental retardation.

(b) Full utilization of the services and facilities available to the State from the federal government for the benefit of mentally retarded persons.

(c) Statutory revisions necessary to carry out the recommendations of the commission.

7608. No administrative authority or responsibility shall be delegated to the commission other than that necessary to plan and execute a thorough inquiry into all aspects of mental retardation.

7609. The commission shall make an interim report to the Governor and to the Legislature not later than October 1, 1964, and shall make a final report to the Governor and to the Legislature by January 15, 1965. The commission shall cease to exist upon adjournment of the 1965 Regular Session of the Legislature.

Sec. 2. There is hereby appropriated from the General Fund the sum of eighty thousand dollars (\$80,000) for the purpose provided for in Part 6 (commencing with Section 7600) of Division 6 of the Welfare and Institutions Code in accordance with the following schedule:

Schedule:

(a) Services----- 110,000

Total of schedule----- 110,000

Less estimated amounts available from other sources:

(b) Estimated grants from the federal government or agencies thereof----- 30,000

Net appropriation----- 80,000

The appropriation made by this section shall remain available for expenditure until June 30, 1965. And in addition, any amounts received from other sources shall be available for expenditure in accordance with the provisions of this section.

Sec. 3. This act makes an appropriation for the current expenses of the State within the meaning of Article IV of the Constitution and shall go into immediate effect.

Appendix B.

ROSTER OF THE STUDY COMMISSION

Jack Halpin, Chairman

Leopold Lippman
Executive Secretary

Harry R. Brickman, M.D.

Leo F. Cain, Ph.D.

Harold D. Chope, M.D., Dr. P.H.
Director, San Mateo County Public
Health and Welfare Department

Mrs. Martin Dinkelspiel

Mrs. J. B. Henn (from March 5, 1964)

E. W. Klatte, M.D. (January 1, 1964, to April 1, 1964)
Director, Department of Mental Hygiene

Mrs. Patricia Lawford (resigned December 27, 1963)

James V. Lowry, M.D. (from April 2, 1964)
Director, Department of Mental Hygiene

Malcolm H. Merrill, M.D.
Director, Department of Public Health

Hon. Jack Morrison
Member, San Francisco Board of Supervisors

John D. Porterfield, M.D. (to December 31, 1963)
Director, Department of Mental Hygiene

Max Rafferty, Ed.D.
Superintendent of Public Instruction

Hon. Nancy E. Smith
Chairman, San Bernardino Board of Supervisors

Warren Thompson (from May 13, 1964)
Director, Department of Rehabilitation

Appendix B - 2

Albert B. Tieburg
Director, Department of Employment

J. M. Wedemeyer, R.S.W.
Director, Department of Social Welfare

Ernest P. Willenberg, Ed.D.

Kent A. Zimmerman, M.D.

MEMBERS OF THE LEGISLATURE

Appointed by the Senate Committee on Rules:

Hon. "J" Eugene McAteer
San Francisco County

Hon. Alan Short
San Joaquin County

Appointed by the Speaker of the Assembly:

Hon. Alfred E. Alquist
24th District, Santa Clara County
San Jose

Hon. Charles Warren
56th District, Los Angeles County
Los Angeles

Appendix C.

GOVERNOR'S CHARGE TO THE COMMISSION

Following is the text of the address by Governor Edmund G. Brown given at the first meeting of the Study Commission on Mental Retardation on October 30, 1963:

Chairman Judge Halpin, ladies and gentlemen:

I am delighted that so many of you were able to attend today. I know how busy you all are, and how difficult it is to find a time which would be convenient for all of you.

I am sure that with the high caliber of membership of this Commission -- and I refer to the public officials and professional people as well as the citizens representing the general public -- you are aware of the issues and that you will confront them earnestly, intelligently and effectively.

Mental retardation is a tremendously important subject -- socially, fiscally and in human terms. It is a handicap that, according to our best estimates directly affects three percent of the national population.

Obviously, mental retardation has a major effect on the lives of all the families of these retarded people. In a sense, it affects every one of us: every Californian, every American. Mental retardation can occur in any family; it does indeed occur without regard to race, religion, national origin, family income, educational level or intelligence of the parents.

There is another sense in which mental retardation affects us all. Every person who is born mentally retarded -- or who, being retarded, is not helped to develop to the limits of his capabilities -- thereby represents a waste of human potential and a cost to every taxpayer. I therefore hope that in addition to your study of the present and needed services for the mentally retarded and their families, you will take an earnest look at the present potential for prevention and the need for research to discover additional information and techniques for preventing retardation.

The mentally retarded, of whom we sometimes speak as a homogeneous group, are actually quite different from each other, with different capabilities, potentialities and needs. They range in age from infants through childhood and adulthood to the elderly. In degree of handicap, they range from the mildly to the severely retarded -- and some suffer from physical or emotional handicaps as well. They vary in family circumstances and, consequently, in the services they require.

For years we have intensified our efforts to reduce the waiting lists for our state hospitals. We have given special budgetary consideration and have made every possible other effort to provide service for those waiting treatment.

Yet we also know that the answer does not lie in the building of more and more state hospitals for the mentally retarded. Service is more important than structures. Fully qualified and professional dedicated personnel are more important than facilities.

Moreover, most services are best provided in or close to the home community, rather than in large, remote institutions.

There must be imaginative approaches -- but there must also be solutions.

The needs of the mentally retarded and their families are many. I might enumerate: diagnosis and parent counseling -- preschool services, including day care and home guidance -- education, obviously of key and strategic importance; and here I should note that there are approximately 53,000 children now enrolled in our special classes -- vocational training and job placement for those who can attain this level of self-reliance -- supervised living arrangements for those who are vocationally competent but need some degree of social direction -- residential care, for the retarded who cannot live in the community -- a program within our state hospitals which facilitates the return of some of the residents to the community -- plus such other areas of service as estate guardianship, religious guidance, and recreational opportunities.

As you members of the Study Commission confront this complex problem, and begin to develop recommendations for consideration of the Legislature, I hope you will keep in mind the concept of a continuum of services for the mentally retarded. It is not enough to have a scattering of services in isolated areas. I ask you to develop a long-range plan and program which will insure that no mentally retarded citizen of California escapes our attention or fails to receive the assistance he needs to develop to his fullest potential, however meager that may be. It is not enough, for example, to develop good educational services and good rehabilitation services; they must be interlocked to serve the individual as a human being, so that the retarded person does not find himself defeated by bureaucratic walls.

California is a rich state, but it is not so rich that it can waste one iota of its greatest resource: its people.

Mental retardation is not only California's problem, not only America's -- it is a worldwide problem. It is also a local problem. I charge you, as the California Study Commission on Mental Retardation, to look at this problem in its broadest aspects -- to bring in recommendations which will acknowledge the mobility of our population and the resources to be found at the local, state, national and international levels. It is not only the State Legislature and the Executive Branch which must act to provide for the mentally retarded and their families; local community services

are crucially important. I also anticipate a close and continuing relationship between our state and the Federal Governments, as there is a shared interest and the opportunity for cooperation.

Moreover, the answers to the social challenge of mental retardation are to be found not only in public agencies, but private as well. The voluntary welfare and health agencies, the devoted and intensely interested citizen organizations, all have much to contribute. Indeed, I sincerely hope you will establish a Citizens Advisory Committee, to add their knowledge and interest to your own.

You are not bound to any past or present pattern of services nor, certainly, of administrative organization. Perhaps there should be additional state agencies serving the mentally retarded; perhaps there should be fewer. Certainly there should be additional and continuing efforts toward coordination and cooperation among those state agencies which have responsibility for any part of the problem.

We have huge assets in the interest of President Kennedy, the current concern of Congress, and the awakening awareness of the general public. No longer is mental retardation a subject to be relegated to the back room, as the retarded child was once kept hidden from society. Today it is recognized that mental retardation, while a tragic occurrence, is no disgrace -- that it may occur in any family -- and that it is indeed a social rather than merely a personal or family problem.

Your task will not be easy -- but you can do it. I wish you well, and I offer you the full resources of my Administration for whatever assistance and support we can render.

Appendix D.

SCHEDULE OF COMMISSION MEETINGS, HEARINGS AND PAPERS PRESENTED

Following is a list of meetings and hearings held by the Study Commission on Mental Retardation since the members were appointed by Governor Brown:

Meetings

October 30, 1963, San Francisco
December 4, 1963, Los Angeles
January 17, 1964, San Francisco Airport
April 17-19, 1964, La Jolla
June 26-28, 1964, Lompoc
September 4, 1964, San Francisco Airport
November 16, 1964, Sacramento

Hearings

December 3, 1963, Los Angeles
January 16, 1964, San Jose

Regional Workshops

October 3, 1964, Sacramento State College
October 10, 1964, University of California, Los Angeles
October 17, 1964, University of California, Riverside
October 24, 1964, University of California, San Diego
October 31, 1964, University of California, San Francisco
November 7, 1964, Fresno State College

Following is a list of letters, statements and other presentations to the Study Commission on Mental Retardation by organization spokesmen and interested citizens from the time of its first meeting, October 30, 1963, to the date of publication of this report.

Sister Miriam Auxilium, M.S.S.W., dean, Holy Family College; director, Holy Innocents Home.

Richard H. Barnett, administrator, Rancho Linda School, San Jose.

Jack W. Bills, M.D., pediatrician, Van Nuys.

Norman Q. Brill, M.D., professor and chairman, Department of Psychiatry, University of California at Los Angeles.

Alta M. Broersma, president, Tri-Valley Association for Retarded Children, Thousand Oaks.

Helma Coffin, supervisor, Special Programs of Education, Division of Secondary Education, Los Angeles City School Districts.

Lawrence E. Coleman, Richmond, president, California Council for Retarded Children.

Mrs. Margarete Connolly, executive secretary, San Francisco Aid Retarded Children.

Moffat Dennis, Protestant chaplain, Sonoma State Hospital.

Thomas W. Harrell, Ph.D., president; Ivan N. Mensh, Ph.D., president-elect, 1964-65; Thomas Gordon, Ph.D., president-elect, 1965-66; California State Psychological Association.

Andrew D. Hunt, Jr., M.D., director of outpatient clinics, Stanford Medical Center; president, Community Council of Northern Santa Clara County.

Robert A. Kimmich, M.D., program chief, San Francisco Community Mental Health Services; president, San Francisco Coordinating Council on Mental Retardation.

Donald J. Kincaid, supervisor, guidance and counseling section, Division of Elementary Education, Los Angeles City School Districts.

E. W. Klatte, M.D., director, State Department of Mental Hygiene.

Richard Koch, M.D., director, Child Development Clinic, Childrens Hospital of Los Angeles.

Fred J. Krause, executive director, California Council for Retarded Children.

Martha T. Leedy, Special Education Advisor, Torrance Unified School District.

Mark E. Lewis, Assistant Superintendent-Instruction, Salinas Union High School District.

Robert W. Lowe, president, Council for the Retarded, East Contra Costa County.

Helen Margulies Mehr, Ph.D., psychologist, San Jose.

Lotte E. Moise, teacher, Paul Bunyan School, Fort Bragg.

Thomas J. Murphy, Santa Barbara Council of Social Work.

Robert O'Reilly, M.D., chief of medicine, Santa Clara County Hospital; president, California Association for Neurologically Handicapped Children.

Mrs. Eye Pecchenino, San Jose.

Robert D. Shushan, executive director, Exceptional Children's Foundation, Los Angeles.

Mrs. Winifred E. Smith, Statewide Council of Chapters National Association of Social Workers.

Michel D. Stein, M.D., pediatrician, Campbell, Santa Clara County.

Mrs. Dorothy W. Sumner, president, San Diego County Association for Retarded Children.

Chester A. Taft, director, Whittier Area Cooperative Special Education Program; president, California State Federation, Council for Exceptional Children.

H. E. Thelander, M.D., Children's Hospital, San Francisco.

Mrs. Ilene Martin Toten, R.N., M.P.H., speaking for a group of eight public health nurses.

W. Elwyn Turner, M.D., director of public health, County of Santa Clara.

Dale C. Williamson, district supervisor, Vocational Rehabilitation Services, State Department of Rehabilitation, San Jose.

David Wodinsky, teacher, Richard Henry Lee School, Los Alamitos.

Appendix E.

ACKNOWLEDGMENTS

The Study Commission on Mental Retardation has appreciated receiving the views of scores of individuals and organizations. Some appeared at the two public hearings of the Commission, December 3, 1963, at Los Angeles, and January 16, 1964 at San Jose. Others have submitted letters or formal statements. The following public agencies and professional and civic organizations are among those who have put their views in writing:

California Association of Administrators of Residential
Facilities for the Retarded
California Council for Retarded Children
California Nurses' Association
California State Federation, Council for Exceptional
Children
California State Psychological Association
Community Council of Northern Santa Clara County
County of Santa Clara
Exceptional Children's Foundation, Los Angeles
Inter Branch Committee, California Psychiatric District
Branches, American Psychiatric Association
Los Angeles City School Districts
Northern California Chapter, American Academy of Pediatrics
Parents and Friends of Retarded Children, Fort Bragg
San Francisco Coordinating Council on Mental Retardation
Santa Barbara Council of Social Work
Southern Section, District Ten, American Academy of
Pediatrics
Tri-Valley Association for Retarded Children, Thousand Oaks

Department of Corrections
Department of Education
Department of Mental Hygiene
Department of Public Health
Department of Rehabilitation
Department of Social Welfare
Department of the Youth Authority

The Study Commission also acknowledges the helpful staff assistance of the following persons, who have served with the Directors of their Departments as active participants in the Commission's work:

William B. Beach, Jr., M.D., Chief
Bureau of Mental Retardation and Children's Services
Department of Mental Hygiene

Francis W. Doyle, Pd.D., Chief
Division of Special Schools and Services
Department of Education

Harold M. Erickson, M.D., Deputy Director
Department of Public Health

Andrew Marrin, Deputy Director
Department of Rehabilitation

Theodore A. Montgomery, M.D., Assistant Chief
Division of Preventive Medical Services
Department of Public Health

George Roche, Ph.D., Chief
Research and Statistics
Department of Employment

Harold E. Simmons
Deputy Director, Program Development
Department of Social Welfare

Finally, the Commission expresses its appreciation to President Clark Kerr, Dean Paul H. Sheats and the staff of University of California Extension for their valuable service in planning and conducting six regional workshops for the Study Commission. Through this means, the Commission's tentative conclusions and recommendations were presented to over 1800 professional persons and other interested citizens throughout California. The reactions of these people helped to refine the Commission's thinking and raise the quality of the final report. The cooperation of University of California Extension made possible an unusual and successful experiment in citizen participation in decision-making on major issues of public policy.

Appendix F.

"STANDARDS FOR STATE RESIDENTIAL INSTITUTIONS
FOR THE MENTALLY RETARDED"
(AMERICAN ASSOCIATION ON MENTAL DEFICIENCY)

On the following pages are reproduced Sections III, IV and V of the Monograph Supplement to American Journal of Mental Deficiency, January 1964, Volume 68, No. 4. Permission to reproduce the material has been granted by the editor of the Journal, Dr. William Sloan.

The sections are:

III. Standards for Institutional Programming.

IV. Standards on Personnel, Training, and Staff Development.

V. Standards on Physical Plant.

SECTION III

STANDARDS FOR INSTITUTIONAL PROGRAMMING

Subsection I. PHILOSOPHY, OBJECTIVES AND PRACTICES IN PROGRAMMING

A. *Minimal Standards*

1. *General*

- a. The institution should be conceived as the "home" (including treatment and training) of the resident (for whatever period in residence) and should provide the kinds of living conditions and services which will insure maximum growth and development.
- b. Institutional programming (as conceived here) involves planning for individual residents in terms of determined abilities and disabilities, potentials for future growth and development, specific services needed, resources available and potentials for release to the community.
- c. Institutional programming also involves homogeneous grouping of the resident population and providing appropriate services for the respective groups.
- d. Effective institutional programming is dependent in large measure upon such factors as philosophy, adequate staff (numbers and competencies at all levels), adequate physical facilities (physical plant and equipment), administrative organization and leadership and financial support.
- e. Of paramount significance in effective programming is the spirit or human atmosphere which pervades the institution involving such factors as mutual understanding, respect and cooperation among the staff, between staff and residents and between the institution and parents and communities.

2. *Specific*

- a. In program planning in institutions for the mentally retarded, provisions should be made for services to all residents (in terms of individual needs) in the following areas:
 - (1) Medical and health care
 - (2) Psychiatric services
 - (3) Therapies and activities
 - (4) Education and training
 - (5) Psychological services
 - (6) Social services

- (7) Speech and hearing services
 - (8) Chaplaincy services
 - (9) Recreational services
 - (10) Residential services.
- b. A favorable atmosphere of mutual understanding, respect and cooperative relationships should be initiated, developed and maintained by the superintendent and his administrative staff.
 - c. Provisions for continuous staff training and development are essential to insure effective institutional programming. (See Section IV, Subsection II.)
 - d. Institutional programming should also include cooperation with colleges and universities in the training of professional personnel.
 - e. In multipurpose institutions, especially in those with large populations, grouping of the residents into homogeneous administrative units of manageable size is essential for effective programming.
 - f. Since diagnostic and evaluative data provide the basis for planning and charting the progress of individual residents, continuous attention should be given to improving the quality and scope of these services.
 - g. Progress in institutional programming is dependent both upon the judicious application of available knowledge and upon the discovery of new knowledge. Every institution should develop a research program which will contribute both to the solution of specific problems of program development within the institution and to general knowledge in mental retardation.
 - h. Institutional programs should be planned to articulate with community programs wherever possible. With 96 per cent of the mentally retarded living in communities, with the rapid expansion of community services for the retarded and with the changing concepts of institutional-community interdependence, it is imperative that institutional programs be articulated with community programs.

STANDARDS FOR SERVICE AREAS

Subsection II. MEDICAL SERVICES

1. *Types of Medical Programming*

Medical care for every resident shall be provided by a staff of competent full-time physicians assisted by an appropriate complement of nurses, physical and occupational therapists, dentists, dental hygienists, sanitarians and related personnel. This care includes the following services:

- a. *Diagnostic*
 - (1) Pre-admission
 - (2) Admission

b. General Medical and Health Care

- (1) Day-by-day medical supervision
- (2) Dispensary and emergency service
- (3) Acute Medical and Surgical Hospital
- (4) Long-term medical and surgical service
- (5) Acute and long-term psychiatric services
- (6) Extra-mural service
- (7) Consultant services
- (8) Dental service
- (9) Special service
- (10) Ancillary medical services
- (11) Preventive medicine

c. Medical Records**2. Diagnostic Services****a. Pre-admission service**

- (1) Before any individual is admitted the case should be reviewed by a staff headed by a physician. This review will vary from case to case. It may include a simple review of the case history reports submitted by various agencies, an interview with the family, an outpatient evaluation of the individual, or a residential evaluation of the individual. Where possible alternate plans for care should be made; where institutionalization is indicated priorities can be established.
- (2) Such pre-admission workup should take place before any individual is committed or indeterminately hospitalized.

b. Admission Service

- (1) Every admission should have the following carried out:
 - (a) Careful detailed family, personal and developmental history.
 - (b) Physical examination including neurological and developmental assessment.
 - (c) Psychological evaluations.
 - (d) Special examination as indicated, i.e., laboratory studies, EEG, x-rays, orthopedic, physical medicine, ENT, and psychiatric.
- c. Every resident shall be classified as to etiology and prognosis.
- d. For every resident there shall be established recommendations as to medication, special therapies, and general program goals.

3. General Medical and Health Care**a. Day-by-day Medical Supervision**

Each resident shall be provided with adequate medical care and supervision. Problems to be handled at this level are:

- (1) General health supervision including personal hygiene.
- (2) Treatment of minor acute illnesses and accidents.

- (3) Regulation of medications employed for extended periods of time such as anticonvulsants and tranquilizers.
- (4) Treatment of behavioral problems.
- (5) General supervision of the residential units with respect to sanitation, nutrition, etc.
- (6) Periodic physical examinations and progress reports on all residents.

b. Dispensary and Emergency Service

- (1) There shall be 24-hour, 7-day-a-week coverage of the institution by a qualified physician. There should be a physician or medically trained person on call at all times.
- (2) Provisions shall be made for the emergency care of acute trauma and minor surgical problems.

c. Acute Medical and Surgical Hospital

There shall be available, either on the grounds or in the community, hospital services to take care of severe illness and surgical problems. These should include an operating room, blood bank, provisions for oxygen therapy, intravenous fluids, and other special treatment as required. These should also include the services of registered nurses and such ancillary medical personnel as is indicated.

d. Long-term Medical and Surgical Services

Provisions shall be made for highly specialized care of problems of medical management such as tube feeding, tracheotomy, complete paralysis, etc. The physician supervising such a ward must give particular attention to problems of nutrition, skin care, sanitation and the prevention of complete physical and mental regression.

e. Extra-mural Service

There should be a clinic to which residents who have been placed in the community but are not yet discharged can return for a complete spectrum of medical and psychiatric services.

f. Consultant Services

There should be available a variety of specialists to serve as consultants in all fields of medicine. These consultants should visit and hold clinics in the institution on a regular basis where possible or be available on a regular basis in the community. The specialties represented are:

- (1) Pediatrics
- (2) Psychiatry including Child Psychiatry
- (3) Electroencephalography
- (4) Neurology
- (5) Neurosurgery
- (6) Orthopedic Surgery
- (7) Physical Medicine and Rehabilitation
- (8) Internal Medicine
- (9) General Surgery

- (10) Anesthesiology
- (11) Ophthalmology
- (12) Otorhinolaryngology
- (13) Radiology
- (14) Pathology

Particular emphasis should be placed on the areas of pediatrics and neuro-psychiatry. Both of these fields overlay greatly in mental retardation and both bodies of knowledge complement each other in understanding the retardate as a whole and separate individual.

Pediatrics is becoming more necessary as the age and developmental level of new admissions have tended to go down. Psychiatry, and particularly child and adolescent psychiatry, are more necessary to help manage the increased institutional population of young people with borderline or mild retardation who have rather severe personality and behavioral disorders.

g. Dental Services

There should be provision for the following:

- (1) Routine care and repair of teeth.
- (2) A program of preventive dentistry including periodic surveys and the teaching of mouth hygiene.
- (3) A program of prosthetic dentistry including the provision of dentures, crowns, bridges and braces.
- (4) Oral surgery.

h. Special Services

There shall be made available to all residents who can derive benefit from the following:

- (1) Physical Therapy
 - (a) Ambulation and muscle reeducation
 - (b) Functional training in the activities of daily living
 - (c) Physical modalities—i.e., heat, hydrotherapy, etc.
 - (d) The provision of braces, walkers, special chairs, crutches and other physical rehabilitation equipment.
- (2) Optical Service
 - (a) The provision of glasses upon the prescription of the ophthalmologist
 - (b) The repair of broken glasses
- (3) Speech and Hearing

This department is more fully discussed under Education. It will work cooperatively with the medical department as follows:

 - (a) The diagnosis of hearing and speech handicaps
 - (b) The prescription and provision of hearing aids
 - (c) The recommendation of special therapies.

i. *Ancillary Medical Services*

- (1) There shall be available the several laboratories necessary for adequate diagnostic purposes including:
 - (a) Pathological
 - (b) Clinical
 - (c) Anatomical
 - (d) X-ray
 - (e) EEG
- (2) There shall be a pharmacy which stocks and dispenses drugs for the institution. There shall be close controls of narcotics, alcohol and other drugs in accordance with federal and state laws. The pharmacy should be under the direction of a registered pharmacist if possible.
- (3) There shall be provisions made for the proper sterilization of syringes, needles, instruments, etc.

j. *Preventive Medicine*

- (1) There should be an organized program of preventive medicine.
 - (a) Immunizations are to be given on a regular basis for Smallpox, Diphtheria, Tetanus, Pertussis, Polio and any other illness deemed necessary.
 - (b) Periodic chest x-rays and skin testing for TB are to be carried out.
 - (c) Provisions shall be made for isolation of communicable diseases and the prevention of their spread.
 - (d) Sanitation shall be periodically inspected and corrected as indicated.
 - (e) Diet shall be adequate, nourishing and tastefully prepared and served in a sanitary manner.
 - (f) Water, milk, ice machines, etc., shall be periodically examined and tested bacteriologically as indicated.

4. *Medical Records*

- a. All records shall be indexed and filed in such a manner as to make the information in them readily accessible.
- b. Each record shall contain sufficient data to justify the diagnosis and the treatment.
- c. Each record shall contain periodic progress reports on physical status and program.
- d. Each record shall contain all legal papers.
- e. Records shall be kept for the period of time specified by the statute of limitations of the respective state.

5. *Release*

- a. There shall be a recorded physical check-up done within 48 hours prior to any type of release.

Subsection II. THERAPIES AND ACTIVITIES

1. *Types*

Efforts to integrate, coordinate and fully utilize the potentials of the various therapies and activities is a relatively new development in institutional programming. Although the terminology and the administrative structure may differ among the institutions, programming should include the following:

- a. Volunteer services
- b. Library services
- c. Music therapy
- d. Industrial therapy
- e. Occupational therapy
- f. Physical therapy
- g. Recreational therapy.

In some institutions physical and occupational therapy may be included in medical programming. In others they may be included in the table of organization of the therapies and activities administrative unit and subject to medical direction.

2. *Purposes*

a. To plan and administer a comprehensive schedule of activities, suited to the individual and group needs of the residents, and contribute to their maximum growth and development. The purposes of such activities are:

- (1) To provide leisure time activities
- (2) To facilitate the development of social skills
- (3) To develop tension-reducing activities
- (4) To promote physical health
- (5) To provide experiences in avocational skills
- (6) To promote the development of motor skills
- (7) To promote functional skills
- (8) To provide for sublimation.

These therapies and activities should be planned in relation to other specialized services, and should play a supporting role to such services and to the total institutional program.

3. In-service training programs should be developed through regularly scheduled staff meetings. Further training should be developed by utilizing local university or college affiliations and promoting attendance at seminars or programs presented at state and national levels.
4. Close liaison should be maintained between the therapies and activities program and all other departmental units of the institution.

5. The above services should provide for all ages and levels of retardation in keeping with their needs.

Subsection III. EDUCATION AND TRAINING SERVICES

1. *Philosophy and Objectives*

- a. Education and training programming within the institution should be conceived and conducted as an integral part of the total institution-community effort leading to the mental, emotional, physical, social and vocational growth of each resident.
- b. Education and training services should constitute a clearly defined area. Its basic responsibility is to provide education and training services to all residents deemed capable of benefiting from such a program.

2. *Organization, Objectives and Scope for Borderline and Mildly Retarded-Educable Residents*

- a. Intellectual development and academic proficiency in tool subjects
- b. The development of emotional stability
- c. The development of good habits of health and personal hygiene
- d. The development of personal and social adequacy
- e. The development of attitudes, interests and skills leading to the wholesome use of leisure time
- f. The development of attitudes, interests and skills leading to good citizenship and community responsibility
- g. Learning to work for the purpose of earning a living.

3. *Provisions for Education and Training Staff*

- a. The suggested education and training staff should include the following according to the needs of the residents and the scope of the program.
 - (1) Qualified school administrators
 - (2) Special education teachers at all levels
 - (3) Vocational instructors
 - (4) Vocational guidance counselors
 - (5) Home economics teachers
 - (6) Music teachers
 - (7) Physical education teachers
 - (8) Speech and hearing therapists
 - (9) Librarian
 - (10) Psychologist assigned to school staff
 - (11) Special teachers proficient in working with those who have emotional, visual and orthopedic handicaps.
- b. All education and training personnel should meet the certification requirements of the State Department of Education in the state in which the program operates.

4. *Assignment of Residents to the Education and Training Program*

- a. Residents should be assigned to education programs on the basis of individual needs.
- b. The number of residents enrolled in academic classes for educable should not exceed 15 in number.
- c. Classes should be coeducational when feasible.
- d. Classes, insofar as possible, should constitute a homogeneous grouping according to criteria as: chronological age, measured intelligence, social maturity, academic achievement, emotional stability, and handicapping physical conditions.

5. *Program Design and Scheduling at Various Developmental Levels*

- a. The daily-weekly schedules should in addition to the academic class-work, provide for all subject areas in the curriculum including activities in creative and practical arts, music, physical education, vocational instruction and home economics.
- b. The recommended minimum number of hours per week to be spent in each area of instruction by a single class at each of the developmental levels is shown in the following table:

| Developmental Level | Recommended Total Time in Educ. & Trng. Classes | Recommended Academic Class Time | Recommended Music Time | Creative & Practical Arts and Home Ec. | Recommended Physical Ed. Time |
|---------------------|---|---------------------------------|---------------------------------------|--|-------------------------------|
| | | | | Arranged according to needs of pupil | |
| Kindergarten | 15 | 10 | 2 | 2 | 1 |
| Primary | 25 | 15 | 2 | 5 | 3 |
| Intermediate | 25 | 15 | 1 | 5 | 4 |
| Advanced | 25 | 15 | 0* | 6 | 5 |
| Pre-Vocational | 30 | 10 | 15-25 hrs. in Related Work Experience | | |

* Elective.

6. *Education and Training Records Should Be Maintained on Each Pupil*

- a. Each education and training department should maintain up-to-date individual school records on all residents assigned to any phase of the program. Minimal records should include the following:
 - (1) A cumulative school record with identification data.
 - (2) Reports of individual mental tests. Psychological evaluation should be reviewed at least every two years and re-evaluation should be done as indicated.
 - (3) Copies of all achievement test batteries. Achievement tests should be given at the close of each school year on all educable level residents enrolled in the school classes.
 - (4) Copies of semester report card for evaluation.
 - (5) All school records should be permanently filed in the school administrative office.

7. *Class Programming*

a. Classes should be provided for educable residents at all levels and to include borderline and mildly retarded above 50 IQ, ages 6 through 18 years and adult education classes for those requiring the service, ages 19 years and over.

b. The criteria for organizational structure and student assignment are:

(1) See Subsection III, 4. Also see Subsection III, 5, b.

(2) Classes should be provided for residents grouped according to the following class levels:

Kindergarten Class Level—For residents between 6 and 9 years of age.

Primary Class Level—For residents between 8 and 11 years of age.

Intermediate Class Level—For residents between 10 and 13 years of age.

Advanced Class Level—For residents between 12 and 16 years of age.

Pre-Vocational Class Level—For residents between 14 and 19 years of age.

Adult Education Class Level—For residents 19 years of age and older.

8. *Special School Supplies and Materials*

a. Teachers should encourage residents to use books other than the specific texts. A wide variety of text books and resource material at various reading levels for each major area should be provided.

b. Encyclopedias, dictionaries and magazines should be made available in sufficient variety and quantity in all classes which can make effective use of these materials.

c. Supplies and materials should be provided for each class in quantity, quality and variety to allow each teacher to effectively conduct activities designed to stimulate interest, develop skills and achieve the objectives of education and training programs. Supplies and materials should be ordered for basic subject areas, and all special subjects included in the curriculum. Large inventories should be avoided and teachers should be allowed to order materials at least twice annually. Experimentation with new materials should be encouraged.

9. *Vocational Training Programming*

a. Vocational training programs should be a planned experience following the pre-vocational phase of the training and education program and should provide for the acquisition of practical knowledge and skills in the use of tools, machines and materials applied in a work setting.

b. Vocational training should culminate in placement outside the institution whenever feasible or assignment to productive employment in the institution when outside placement is not possible.

- c. All areas of the residential institution deemed suitable for vocational training purposes should be utilized.
 - d. Where appropriate, all residents should have an occupational evaluation, including aptitude tests, interest inventories, and achievement tests in basic academic skills prior to placement in vocational training program.
 - e. The services of the Vocational Rehabilitation Administration should be utilized:
 - (1) As a part of the vocational training program
 - (2) By referral to this agency for further training and community placement.
10. *Organization, Objectives and Scope for the Moderately Retarded-Trainable*
- a. The development of self-help skills, safety, social and interpersonal relationships, and speech and language skills necessary to increase their potentials for more independent living.
 - b. The development of emotional stability.
 - c. The development of good habits of health and personal hygiene.
 - d. The development of attitudes, interests and skills leading to a more wholesome use of leisure time.
 - e. The development of social attitudes and behavior patterns necessary for more adequate group living and participation.
 - f. The development of work habits, skills and tolerances for work for the purpose of personal satisfaction and usefulness in a sheltered environment.
11. *Provisions for Training Staff*
See Subsection III, 3 for Educable.
12. *Assignment of Residents to Education and Training Program*
- a. See Subsection III, 3 for Educable.
 - (1) The enrollment in classes for moderately retarded (trainable) should not exceed 12, preferably less under certain conditions.
13. *Program Design and Scheduling*
- a. The daily-weekly schedules of education and training programs for moderately retarded should provide for instruction in all areas in the curriculum including activities in self-help skills, creative and practical arts, music, physical education, occupational and home training.
 - b. The daily-weekly schedule of education and training programs for moderately retarded children should be no less than four hours per day five days per week.
14. *Class Programming, School Supplies and Materials and Occupational Training*
See Subsection III, 7, 8, 9 for Educable.

Subsection IV. PSYCHOLOGICAL SERVICES

While psychological personnel should not assume direct administrative responsibility for the management of the residents, they should, through consultation, assist those institutional departments which have these administrative responsibilities.

Programming should include psychological services to the residents of the institution, to the administration, and to other institutional departments whose responsibilities involve the day-to-day care and training of the residents.

1. Responsibility may vary somewhat in institutional settings according to the administrative organization of the institution. The professional background of a department of psychological services equips it to fulfill the following responsibilities.

- a. *Intellectual Classification*

The clinical psychologist has at his disposal many assessment instruments, and in each case should choose those most appropriate for the resident's chronological age and ability level. All classifications should be current and prognostic in nature and should have a clinical basis rather than a rigid IQ basis.

- b. *Consultation and Reporting*

- (1) Analysis of the mental and emotional characteristics should lead to recommendations regarding programming. These should be specific in terms of the needs of any particular resident. These recommendations must come within the scope of facilities available in the institution or in the community.
- (2) Report forms may vary but they should be concise and meaningful in terms of the resident's programming. Consultations with the referring department should be initiated following contact with the resident and continued periodically throughout the resident's stay in the institution.

- c. *Counseling and Therapy*

- (1) With psychiatric personnel in residence, the respective responsibilities of the psychiatrists and psychologists should be clearly defined. Varied techniques, such as play therapy, group therapy, environmental therapy, supportive therapy, and more intensive therapy may be employed depending upon factors such as chronological age, intellectual ability, and personality characteristics of the resident. In institutions where there are no resident psychiatrists, psychiatric consultants should be made available. Therapy notes should be kept following each session and periodic conferences held with referring departments.
- (2) Much of this therapy will become the responsibility of the psychologists in institutions having no psychiatrist in residence. Personality dynamics and the use of personality and projective techniques

enable a department of psychological services to make major contributions in this area, one which is necessary to the understanding of the adjustment of the mentally retarded. In institutions where there are psychiatrists in residence, contributions of a department of psychological services should serve as a complement to the work of the psychiatrists.

d. *Training and Selection*

A department of psychological services should also be equipped with assessment techniques to aid in the selection of institutional personnel and to participate effectively in the institutional in-service training program. Through a more formal internship program the department should assume the responsibility for training psychologists in the area of clinical psychology.

e. *Administration and Staffing*

The basic organization of a department of psychological services should include the research area and the clinical area. These areas should be well defined in terms of their responsibilities, including maximum inter-area communication with minimal overlap.

f. *Integration with Other Services*

The administrative organization of the institution should provide for the integration of the various service departments. This may have its formal aspects involving channeled memos, committees on programming, administrative staff meetings, and in-service training programs. It should encourage informal and direct contact among all levels of personnel in order to achieve maximum integration.

Subsection V. SOCIAL SERVICES

The social service department provides a liaison and coordinating service in behalf of the retarded person, between the residential facility, the family of the retarded person and community resources. Retarded persons and their family should be assisted by the social service department in every aspect of their problem from the time of the initial contact with the residential institution through application and pre-admission counseling where applicable, through social casework and group work therapy during residence, planning for return to the community, and continued social work counseling of the employment or home placement until discharged. This should be closely coordinated with other departments within the institution.

1. *Philosophy and Functions*

- a. Administration of the application procedure, including individual and family counseling, liaison and planning with community agencies, preparation of psychosocial data to assist in diagnosis, participation in the processing of the application to the waiting list status or to the admission of the individual.
- b. Provide casework and group work services to the retarded and their

- families while awaiting admission and consult with clinic staff, physicians, community agencies involved in planning for the retarded individual while awaiting admission to the residential institution.
- c. If a facility has its own admissions procedure, caseworkers may be used to gather information concerning the mentally retarded person and his environment prior to admission.
 - d. An admissions committee should study each case to evaluate the need for admission to the facility, noting the possibilities of utilizing community resources.
 - e. The case history should be prepared so that the data will help in the diagnosis, training and understanding of the resident. Facts required by departments within the institution should be included on a face sheet.
 - f. Social service programs in the institution should include family counseling and consultation to assist in the resident's adjustment, participation in the program planning for each resident, counseling as a member of a treatment team, rehabilitative services to those residents being prepared for community placement either in employment or foster and/or boarding home situations. The social service department should encourage continuing contact and interest of resident's family.
 - g. The social service program should include casework with individual residents while living within the facility.
 - h. Community placement program: Employment, foster and/or boarding home placements, consultation with community training and placement agencies, placement of, and continued counseling with, the resident in the community until discharge.
 - i. The social service department should participate in the selection of placement referrals. Residents who have completed the training cycle at the institution and are able to perform on job placements should be recommended for placement from the appropriate committee.
 - j. The social worker should fully utilize the resources in the community for job finding and home finding.
 - k. Social workers should act as liaison between the institution and other agencies outside of the institution in behalf of individual residents.
 - l. The social service department should participate in total institutional programs.
 - m. The social service department should take an active part in parents groups both within the institution and in the community.

Subsection VI. SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

Increasing attention is being given to institutional programming in speech pathology, audiology and research (SPAR) because of the multiplicity of speech and hearing problems found in the retarded population. The principal functions and services are:

1. *Diagnostic*

- a. Speech evaluation
- b. Language and communication appraisal
- c. Hearing screening, testing and diagnosis
- d. Hearing aid evaluation program
- e. Diagnostic therapy (differential diagnostic examinations).

2. *Therapeutic Training (Not included in Education and Training Programs)*

- a. Speech programming, including speech correction, speech (lip) reading, auditory training, and hearing aid utilization offered individually or in small groups.
- b. Speech training and speech education, individually or in small groups.
- c. Language development and speech stimulation offered in group therapy, to infirm, non-ambulatory, or nursery living care areas.
- d. Auditory training in relation to problems of instruction, offered on the pre-school, kindergarten, or school classroom level, and in relation to all phases of clinical activity.

3. *Reporting and Interpretation*

The program should strive to maintain the highest professional level of accurate reporting within the framework of the institutions' reporting system.

4. *Consultation Services*

- a. Ear, nose, throat clinic support to the medical clinic
- b. Psychological support as indicated
- c. Parent counseling, referral, and guidance
- d. Vocational rehabilitation coordination, especially in matters of the procurement of prosthetic devices, i.e., hearing aids, orthodontic devices, etc.
- e. Audio-visual coordination, training, and maintenance where indicated.
- f. Speakers bureau coordination of activities and public relations, where indicated.
- g. Outpatient diagnostic work, testing and referral, where indicated.
- h. Coordination with education and all other departments.
- i. In-service training programs for special education teachers, cottage personnel, nurses, medical staffs, psychology, vocational counselors, etc.

5. *Organization*

- a. In a clinical program of SPAR, there are three separate divisions of job performance and responsibilities: speech pathology, audiology, and research.
- b. An important factor relating to integration with other services is the

requirement that an effective speech pathology, audiology and research (SPAR) program should maintain itself as an individual profession within the administrative framework. Since SPAR represents a multi-disciplined area of specialization, effective communication with other departments and services is highly essential.

Subsection VII. CHAPLAINCY SERVICES

There shall be provided a chaplaincy services program for residents in the major faith groups in all institutions for the mentally retarded.

1. *Philosophy and Functions*

a. The program of chaplaincy services is based on the conviction that worship, the acquisition of adequate religious concepts, the development of social and ethical values and the availability of the pastoral rites and ministries of the historic faiths are necessary for wholesome personality growth.

b. The following elements are regarded as basic in the chaplaincy program:

(1) Regardless of the size of the institution, provision should be made for regular worship services in the three major faiths. Provision should also be made for observing recognized religious holidays in all faiths.

(2) Provision should be made for religious instruction and counseling.

c. Provision should be made for pastoral services. An adequate chaplaincy services program in institutions for the retarded should include the following activities commonly referred to as pastoral activities.

(1) *Administration of Rites and Sacraments*

The rites and sacraments of the faith groups should be administered to residents in accordance with requirements of the respective faiths.

(2) *Counseling*

The chaplaincy program should provide residents with the opportunity for counseling by chaplains.

(3) *Visitation Program*

(a) The sick

The chaplaincy services program should provide regular visiting by the chaplain of the sick in the hospital wards and/or in the living units.

(b) The living and recreation areas

An adequate chaplaincy services program should require budgeting of time by the chaplains to afford frequent visiting of residents in their living and recreation areas.

2. *Responsibilities of Institutions to Chaplains*

To the extent that wise management of available resources permits, institutions should furnish chaplains, the facilities, equipment and materials needed for efficient operation of a chaplaincy services program.

Subsection VIII. RECREATION SERVICES

Recreation programming should provide each resident with enjoyable leisure time activities and promote mental and physical health through interesting and worthwhile recreational pursuits.

1. *Purposes*

Recreation services should provide:

- a. A program which will insure participation by all residents according to their interests and abilities.
- b. Planned recreational activities which are purposeful to the continued mental, physical, and social development of the resident.
- c. Planned coeducational activities which will serve to develop healthy social relationships with members of the opposite sex and acceptable social behavior.
- d. Opportunity for social interchange in a variety of environmental settings, some away from the residential institution.
- e. A sports program which will encourage competition with others of comparable ability. This includes an intramural sports program.
- f. Instruction in a variety of hobbies.
- g. Instructions in the safe use of all recreational equipment and supplies.

Subsection IX. RESIDENT LIVING SERVICES

1. *Philosophy and Functions*

The resident unit in the institution is the operational home setting throughout the individual's residence. Its personnel carry many routine as well as exceptional, responsibilities in the course of any 24-hour period. Depending on the age, sex, intellectual and social level, and physical-medical status of the resident, the unit may provide all functions and the complete program or it may be only the home base for the resident's activities and program. The resident unit must be so organized, structured and operated within the scope of both the general and specific responsibilities to appropriately anticipate, plan, and meet the varied personal requirements of the residents.

- a. The resident unit shall provide a pleasant, stimulating, attractive, home-like environment in support of the comfort and care of the residents with proper respect for both their privacy and fellowship.
- b. The resident unit shall support the functions of daily living through adequate personnel, program and facilities.

- c. Grouping in resident units shall be on a planned classification basis to provide compatibility among residents and an effective program base for residents of similar age and sex (beyond early childhood), social, intellectual and functional levels and physical capabilities.
- d. Services provided in the resident unit shall have distinctive characteristics identifiable as primary responsibilities of the unit in meeting the developmental potential of the resident, or as supporting or complementary to other divisions of the institution.

2. Housing

- a. The resident unit shall provide for not more than 30 residents.
- b. Its design and construction shall support the needs of its residents and be functional in respect to the unit program. It shall include the following elements where applicable:
 - (1) Living room, day room, play room—supplemented by smaller rooms for diversified use and to provide privacy
 - (2) Dormitory and/or sleeping rooms
 - (3) Bath, toilet and dressing rooms
 - (4) Clothing room
 - (5) Dining room
 - (6) Preparation-serving kitchen and pantry
 - (7) Clinic and counseling room
 - (8) Reception and visiting space
 - (9) Linen room
 - (10) Dirty laundry space
 - (11) Staff office
 - (12) Toilets and lavatory (Residents and Personnel)
 - (13) Classroom and special activity space (reading, study)
 - (14) Laundry and utility unit
 - (15) Barber/beauty space for residents who must receive service on the unit
 - (16) Out-of-season storage
 - (17) Private space for residents personal belongings (lockers, wardrobes)
 - (18) Janitorial storage
 - (19) Space provision for wheel chairs and vehicle toys
 - (20) Storage space for toys, games, activity materials
 - (21) Covered porches, playground sun shades and/or arboretum.
- c. Furnishings and equipment shall be varied in size and design for various classifications of residents.
- d. Comfortable temperatures shall be maintained at all times under thermostatic control on an area basis.
- e. All spaces shall be ventilated by windows, ducts, or mechanical means to provide a proper circulation of air and to eliminate objectionable odors and condensation without inducing drafts.

- f. The basic furnishings of the resident unit shall be augmented effectively by decorations, pictures, planters, book shelves, cases, curtains, etc.
- g. Interior surfaces and finishes shall be in pastel colors.
- h. All spaces shall be lighted to provide a degree of illumination appropriate for the function of the room.
- i. Doors shall be outward opening and equipped with self-closing devices. Doors and windows shall be provided with effective screens or insect repelling devices.

3. *Housekeeping-Safety-Sanitation*

- a. Janitorial equipment shall be supplied or easily available in each resident unit. Equipment shall be mechanized to eliminate laborious, non-therapeutic practices.
- b. Janitorial supplies, meeting approved specifications for special purpose use, shall be issued for each housekeeping chore.
- c. A housekeeping schedule of routine and special duties shall be maintained.
- d. Personnel shall be trained in fire prevention, reporting and suppression; safety measures; severe weather procedures and civil defense measures. Fire extinguishers and other emergency equipment shall be provided in accordance with governing codes.
- e. A qualified person shall make a fire and safety inspection of the unit at least monthly. Resident unit personnel shall maintain a continuous surveillance taking immediate action to eliminate hazards and infractions.
- f. Residents shall be trained in evacuation routines.
- g. Medications available on the unit shall be stored in a locked cabinet and administered only as prescribed by a physician.
- h. Measures shall be taken to provide the services of an exterminator to keep the unit free of vermin, roaches, rodents and any like infestation.
- i. All equipment and furnishings shall be of a design and material that can be readily cleaned and/or sanitized and of such construction to insure against injury.
- j. Ready access and egress to all areas of the unit shall be provided and maintained for convenience, mobility and safety in accordance with Fire Underwriters regulations.
- k. Paint on play equipment and furniture shall be lead free.
- l. Stairways and ramps shall be provided with non-skid materials or treads and handrails. Angle of ramps shall not exceed 30 degrees.
- m. Any area of the unit contaminated by the incontinence of residents shall be cleaned and disinfected immediately.

- n. All soiled linens and personal clothing shall be bagged, removed from the unit and frequently delivered to the laundry.
 - o. Trash shall not be permitted to accumulate in any area. Receptacles shall be provided and shall be emptied at least once daily.
 - p. Thermostatically controlled mixing valves with safety alarm systems shall be provided on all hot water lines to which residents have access. Temperature is not to exceed 110 degrees at the tap.
 - q. All heating units shall be so located and protected to prevent injury to residents.
 - r. When smoking is permitted in the unit by residents and personnel, proper safety precautions shall be observed.
4. *General Health-Personal Hygiene-Physical Care*
- a. Each resident shall have a shower or tub bath daily.
 - b. All bathing shall be closely supervised by resident personnel.
 - c. Residents shall be thoroughly bathed and dried with individual wash cloths and towels.
 - d. Residents who are incontinent shall be bathed and clothes or bed linens changed immediately.
 - e. Teeth shall be brushed at least twice a day with an effective dentifrice, utilizing a proper technique. Individual brushes shall be used and proper storage provided. Mouths shall be examined and any unusual conditions reported.
 - f. To insure proper sanitation, personnel and residents shall meticulously wash hands after handling an incontinent resident or soiled clothing or linens. Like precautions shall be followed in respect to contacts with infectious and contagious diseases.
 - g. Routines for grooming shall be established to be carried out on rising, before and after meals, at bedtime and at such other times as occasions demand. Individual toilet articles shall be available or provided for each resident with provisions for their proper storage.
 - h. Procedures for monthly weighing of residents and maintenance of weight records shall be established.
 - i. Cutting of toe and finger nails for residents shall be scheduled at bi-weekly intervals.
 - j. Daily screening of residents shall be done for medical referral.
 - k. Illnesses, accidents, injuries shall be reported to the medical department immediately.
 - l. Records shall be kept of menstruation periods, convulsive seizures and any other incidents that may effect the resident's health and welfare.
 - m. Personnel shall be trained in first aid procedures and shall have first aid supplies at their disposal at each residence. Record shall be made of any first aid treatment and report made to the medical department.

- n. Mechanical protective restraints shall be used only to prevent self-abuse and destructive action in extreme situations and only when prescribed by a physician. Restraints shall be so applied that speedy removal is possible. Record shall be made of each period of restraint, including duration and justification. Restraints shall be checked frequently while in use.
- o. Prescribed use and care of eye glasses, dentures, hearing aids, orthopedic appliances, etc., shall be assured.
- p. Waterproof mattresses or mattress covers shall be used on beds of those residents who are incontinent or enuretic to prevent contamination.
- q. Male residents shall be programmed for hair cutting and shaving, and female residents for hair cutting, permanent waves, and hair styling on a scheduled frequency which will contribute to the residents' well groomed and proper appearance at all times.
- r. All residents shall have planned, supervised periods out-of-doors. Caution shall be observed in order that overexposure to the sun does not occur and that residents are protected from any extremes of weather.
- s. Multiple handicapped and non-ambulatory residents shall have planned daily activity or exercise periods out of bed, except when contraindicated by the medical department.
- t. Residents who are unable to use drinking fountains will be given water or other liquids at intervals and in sufficient amounts to assure adequate fluid intake and to prevent dehydration.
- u. Each bed shall be supplied with a quality spring and mattress that is without sag to maintain healthful sleeping posture and comfort.
- v. Records shall be kept of all general health, personal hygiene and physical care procedures administered in the resident unit to properly supplement the hospital medical records.

5. Food Service

- a. Three systems of food service are recognized:
 - (1) Meals prepared and served on a resident unit basis.
 - (2) Meals prepared in a central facility, transported to and served in the resident unit.
 - (3) Meals prepared and served in a central facility.
- b. When transportation of prepared food is required (as in a.(2) above), vehicles designed specifically for this purpose shall be used. Such food carts, etc., shall provide for hot and cold menu items.
- c. Central preparation and service of meals (as in a.(3) above), may be utilized for residents who are fully ambulatory and who are capable of self-service in a cafeteria.
- d. A nourishing, well-balanced diet shall be provided under professional supervision.

- e. Food shall be served in an attractive manner, in sufficient quantity, using a full table service when appropriate.
- f. There shall be no re-use of certain foods, so specified by dietetic and medical authority.
- g. Dining rooms shall be supervised to direct self-help eating procedures.
- h. Feeding of nursery and infirmary residents shall conform to, and be directed by the best pediatric and nursing procedures.
- i. Tables shall seat no more than six residents.
- j. Tables shall have smooth, impervious surfaces, free of cracks and holes or be covered with a cloth.
- k. Adequate facilities shall be provided for storage, preparation and serving of foods.
- l. Adequate refrigeration shall be provided for all perishable foods.
- m. There shall be a dishwashing machine of adequate capacity with water supplied for washing and rinsing at a temperature to assure thorough cleansing and sterilization. Thermostatic controls and temperature gauges shall be in operating condition at all times.
- n. Closed dish cabinets shall be provided for between meal storage of dishes.
- o. All food service procedures shall comply with state and local food handler's regulations.
- p. Handwashing facilities shall be provided in all food service areas.
- q. Special diets shall be prepared for individual residents as prescribed, as well as special nourishment between meals, and pre-bedtime snacks.
- r. Mechanical garbage disposal units shall be used as essential equipment. (If local ordinances prohibit use of disposal units, garbage shall be stored in metal containers with tight fitting covers. Cans shall be emptied daily and thoroughly cleaned on interior and exterior after use.)

6. *Clothing-Laundry Linens*

- a. Each resident shall have an adequate allowance of neat, clean, seasonal clothing. Its design and quality shall develop self-respect. Shoes shall be of comfortable fit and attractive style.
- b. Each resident shall have his own clothing, so marked for his personal use. Clothing shall not be used in common.
- c. An inventory shall be kept of all personal and clothing items denoting source, and final disposition when discarded.
- d. Storage space shall be provided in a clothing room to which the resident shall have access under appropriate supervision.
- e. Clothing shall be regularly inspected for mending and cleaning.
- f. Shoes shall be inspected for frequent shines and necessary repairs.

- g. Individual bath towels and wash cloths shall be supplied.
- h. Dirty personal laundry of the resident shall be removed from the living area of the unit and dirty linens shall be sent direct to the laundry.
- i. Automatic washers, dryers, irons, sewing machines may be utilized on the unit by some classifications of residents.
- j. Separate storage shall be provided for clean linen and used exclusively for this purpose.
- k. The resident shall be provided private storage space for personal belongings to which he shall have access.
- l. A clothing and shoe supply center shall be maintained from which the resident may be permitted to make individual selection of apparel.

7. *Recreation and Leisure Time Activities*

- a. Planned Recreation programs may be a part of the over-all institution Recreation program. (See Subsection VIII on Recreation.)
- b. Unit Activities
 - (1) Televisions, radios, record players, pianos, etc., shall be given location and usage that will not be in conflict, but will contribute to both group and individual interests.
 - (2) Toys, games, magazines, puzzles, etc., shall be readily available.
 - (3) Work-play tables shall be provided.
 - (4) Activity and play space outdoors shall utilize porches, lawns, groves and playground adjacent to the residence.
 - (5) Playground equipment suitable to the age, social level and physical capacity of the resident shall be available on the unit playground area.
 - (6) Individual and group activities shall be encouraged, fostered and planned. This programming may include letterwriting, scrap books, story telling, collections, contests, picnics, parties, socials, special holiday events, etc.
 - (7) Hobbies and semi-vocational activities shall be encouraged.
 - (8) Free play opportunities, as well as periods of relaxation shall be provided.
 - (9) Bicycles, roller skates, vehicular toys shall be utilized.

8. *Training*

- a. The resident unit shall operate as a developmental center in its plan and approach to all daily functions and responsibilities.
- b. Progressive training shall be established for each resident on an individual basis for development of maximal independence in the general category of self-help skills and performances. These are recognized to include dressing, undressing, eating, bathing, personal hygiene procedures, toilet care, etc.
- c. A proper regard shall be given to ethical values and religious devotions

such as grace at meals, bedtime prayers, personal devotions and weekly attendance at chapel shall be encouraged.

- d. Self-government, participation in unit management procedures, shall be developed with responsible residents.
- e. Self-management shall be the goal when disciplinary measures such as rewards, privileges, and restrictions are used. Abuse, neglect, favoritism, or undue familiarity shall not be tolerated in personnel-resident relationships.

9. *Family Relationships*

- a. The parents and other authorized family visitors shall have access to the resident unit within the regulated visiting hours. A cordial welcome shall be extended to all authorized visitors.
- b. The personnel of the unit shall be well informed in their area of direct responsibility for the resident and be capable of interpreting the resident's status in these areas.
- c. The personnel shall be so informed as to be able to properly direct the family to contacts with the professional staff in matters outside the unit personnel's direct responsibility for the resident.
- d. The resident unit shall be the meeting ground for the resident's family, the resident and the unit personnel and shall provide the opportunity for parental participation. A relationship of mutual understanding and respect shall be developed.

10. *Professional Relationships*

- a. Knowledge of professional services and functions of professional personnel shall be provided resident personnel as a part of an initial orientation program.
- b. Personnel of the professional services shall provide the resident personnel with information of the developmental status of all new residents.
- c. The resident unit shall serve as a practical study center of the developmental progress of residents to be utilized by the professional departments of the institution.
- d. Personnel of the unit shall be a reliable information source on the status of each resident. Records of progress, development and special performances shall be kept for utilization by the unit and professional personnel.
- e. Unit personnel shall play a supporting role in the ancillary and professional services of the institution in the special therapies that may involve individual residents. Professional personnel shall understand and respect the area of responsibility of the unit personnel.

Subsection X. ARTICULATION OF INSTITUTION AND COMMUNITY

1. *Philosophy and Purposes*

- a. The institution through its programming should strive to acquaint community agencies and the general public with its purposes and program.
- b. It should strive to create in the public mind a more realistic understanding of the causes of mental retardation and of the possibilities in prevention, treatment, training and care.
- c. It should strive to establish close working relations with communities.

The institution has many specific needs which communities can help to meet. In turn, communities have many specific needs which the institution can help to meet within the framework of state laws and availability of staff.

2. *Volunteer Services*

- a. The role of the volunteer is to assist the staff in providing better care, treatment and training for the resident.
- b. The scope of the use of volunteers is limited only by the ability of staff members to recognize a need which can be filled by a volunteer. A need must exist and not be created in order to use volunteers.
- c. There should be a full time staff member whose responsibility should be that of directing and coordinating a volunteer program for the total institution.
- d. There should be a volunteer services committee composed of representatives of various organizations of the community. Such a committee should act in an advisory capacity to the coordinator of volunteers.
- e. Initially, volunteers may be acquired through the various media of communications with the community. These volunteers will in turn help to bring in other volunteers.
- f. Sources of volunteer assistance may include civic organizations, churches, schools (colleges and high schools), Campfire Girls, Girl Scouts, Boy Scouts, Parents' organizations, Volunteer Bureaus, Child Conservation Leagues, fraternal organizations, labor organizations, etc.
- g. Standards for volunteers should be printed and distributed for all volunteers as well as staff. The volunteers shall be given orientation and training to a degree commensurate with their specific assignment. Volunteers should be subject to the same rules and regulations as paid employees.

3. *Professional Services*

- a. An effective, dynamic, professional and operational program should be developed and maintained between the institution and colleges and universities.

- b. The resources of the institution should be available for training and programming in all professional disciplines.
 - (1) Externes in all professional areas where the institution is accredited for such programs.
 - (2) Internes in all professional areas where the institution is accredited for such programs.
 - (3) Student teaching, field experience and other similar services either for credit or non-credit should be provided.
- c. A formalized program of interchange of staff, possibly a dual staff arrangement, should be initiated, encouraged, and maintained, wherever feasible, with cooperating universities and colleges.

4. *Community Services*

- a. The resources of the institution should be available for diagnosis and training for community agencies and individuals who may benefit from such participation.
- b. This diagnosis and training can be accomplished through the following suggested means:
 - (1) Outpatient clinics for diagnosis
 - (2) Admission of outpatient individuals into such programs as:
 - (a) Special classes
 - (b) Speech and Hearing
 - (c) Pre-vocational
 - (d) Vocational
 - (e) Sheltered Workshops.
 - (3) The services of all other disciplines within the institution should be available when necessary or desirable.

5. *Tours and Public Relations*

- a. To implement institutional programming through administrative channels by such means as:
 - (1) The use of news media: newspapers, publications, radio, television.
 - (2) The development of a speaker's bureau providing, on request, well informed, authentic information on the institution, its purpose, operation and problems.
 - (3) Tours for persons and groups interested in the nature and scope of services provided by the institution.

Subsection XI. RESEARCH PROGRAMMING

Future progress in institutional programming is dependent both upon the effective application of present scientific knowledge and upon the discovery of new knowledge. It is assumed that institutions will continually strive to base their programming in treatment, training and care upon the most up-to-date scientific knowledge available. It is also assumed that institutions

have not only an opportunity, but an obligation to contribute to advances in new scientific information through research.

Institutions should work toward the following research goals:

1. To provide for the administration of an organized program of research and seek funds for this purpose.
2. To encourage and support institutional personnel with demonstrated research interests and ideas to carry on research by making the necessary resources (time or money or both) available to them.
3. To cooperate with universities and other research agencies in making research facilities available.
4. To stimulate research efforts (both individual and programmed research) which will contribute, not only to the improvement of treatment, training and care within the institution but to new knowledge about mental retardation.

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SECTION IV
STANDARDS ON PERSONNEL, TRAINING AND
STAFF DEVELOPMENT

Subsection I. STANDARDS ON PERSONNEL

A. *Minimal Standards*

1. *General*

- a. The institution shall procure and retain those persons whose personal, professional and technical qualifications will lead to the attainment and purposes of the institution.
- b. The institution shall seek to employ only those persons who are at least equal in competence to those employed in similar or related agencies in the community.
- c. The ethical standards developed by the professions shall be accepted as standards by the state institutions.
- d. Personnel shall be in sufficient numbers in all areas so that the operation of the institution will not be dependent upon the use of residents for productive service.

2. *Specific*

- a. Each position which requires licensure or certification for employment in the community shall require similar licensure or certification in the institution.
- b. All personnel shall be physically well and free of any significant personality or characterological deviations.
- c. Working conditions shall be equal to or superior to those in the general community for similar work.
- d. Positions shall all be classified in accordance with a merit system.
- e. Each position shall be analyzed as to the minimum and desirable requirements, the duties described, and the minimum and desirable qualifications for the incumbent shall be stated in writing.
- f. Induction and orientation training shall be provided so that the employee may quickly become familiar with the organization and his place in it.
- g. Regular and periodic evaluations of the employee's performance shall be made and communicated to him.
- h. In-service training shall be made available for all employees requiring extensive technical training, and whose pre-employment training and experience do not equip them with skills for the most effective contribution.

- i. Tenure shall be encouraged through merit system protections plus providing opportunities for promotion and transfer as development progresses.
- j. There shall be adequate work space and equipment to promote efficiency and to assure employee safety and welfare.
- k. The health and physical welfare of employees shall be safeguarded by a sound safety program and employees' health and medical services. Employees working directly with residents or in food service shall be given regular and frequent health inspections and examinations as may be required by health laws.
- l. Regular vacations, holidays and sick leave shall be provided.
- m. Efforts should be made to improve the welfare, effectiveness and security of employees through such devices as retirement or social security plans, employee organizations, employee recreation and social activities, health and accident insurance programs and credit union.

B. *Personnel by Functions*

1. *Superintendent*

There shall be a chief executive officer or administrative head of the residential institution who may be called superintendent or director or some similar title. He shall have responsibility for both administrative and professional leadership subject to the authority of the parent agency or organization which appoints him. It is highly desirable that the chief executive officer or superintendent be recognized as having achieved a high level of competence in one of the professions which normally assumes a significant role in the work with the mentally retarded. The preferred professional orientation will vary with the particular character of the institution.

If a physician, he shall be licensed to practice in the state or province in which the institution is located. He shall have had at least five years of progressive experience in institutions for the mentally retarded or related institutions such as mental hospitals. Formal training leading to certification in pediatrics, neurology, or psychiatry may be substituted for the progressive experience on a year-for-year basis. Certification of eligibility for certification may be substituted for up to three of the five years experience. In addition to the professional training and experience the physician shall have had formal training and experience in administration and supervision. Certification in mental hospital administration should be accepted as evidence of having achieved training and experience in administration.

If not a physician, the chief executive officer or superintendent shall have achieved training in psychology, social work, education, public administration or management to the level of the Masters degree, and shall have achieved certification or be eligible for such certification if such is available in the state of residence. He shall have had training and experience in supervision and administration, and he shall have had at least five years

of progressive experience in an institution for the mentally retarded. Related experience such as public school administration or supervisory or administrative experience in other types of institutions such as mental hospitals or children's treatment institutions, etc., may be substituted for up to two of the five years of progressive experience.

2. *Assistant Superintendent*

The assistant superintendent, where such is appropriate, shall be the first assistant to the superintendent, and in the latter's absence serves in his place. In some institutions the assistant superintendent may also have another assignment such as clinical director, director of education and training, director of research and training or director of the cottage life program. In others a pattern may be established where no single assistant superintendent is named but one or more of the heads of major functional units or administrative departments are appointed or assigned to function in this role in rotation.

If the assistant superintendent is a physician, he shall have qualifications similar to those outlined for the superintendent except that he shall have had three years of progressive experience in an institution for the mentally retarded or its equivalent. In addition he shall have had training and experience in administration and supervision.

If the assistant superintendent is not a physician, he shall have achieved training in one of the professions equal to that outlined for the non-medical superintendent. He shall have had three years of progressive experience in an institution for the mentally retarded or its equivalent. In addition he shall have had training and experience in administration and supervision.

3. *Clinical Director (Director of Professional Services or Program Director)*

Many institutions will find it advantageous to establish a position, the function of which shall be to provide leadership to those professional groups primarily responsible for establishing the clinical diagnosis and formulating a program of care, treatment and training for each resident. The person filling this position may be known as the clinical director, director of professional services or program director, depending on the size and organization structure of the institution. He may also be responsible directly or through assistants for the integration and coordination of the care, treatment and training program for each resident and for the periodic reevaluation of the resident and his progress.

The clinical director shall have qualifications similar to those outlined for the assistant superintendent. Larger institutions may find it desirable to have two or more clinical directors with each having the above mentioned responsibilities for a section of the resident population.

4. *Management or Administrative Services*

a. *Business Administrator*

(1) There should be available a trained and experienced person to serve

as the superintendent's assistant in the direction and coordination of the management and service functions of the institution. He may be called administrative director, hospital administrator, business administrator or business manager and occasionally assistant superintendent for business or management.

- (2) This officer should have completed college training in business administration, management or hospital administration and have three years of experience in administration or supervisory positions with at least one year in an institution for the mentally retarded.

b. Finance, Disbursements and Budget

- (1) This division should be responsible for (a) the preparation of the institution's annual budget from information supplied by the operating departments, divisions and sections of the institution, (b) the disbursement of funds through the accurate management of requisitions and use of modern cost accounting methods, (c) general accounting and auditing covering all financial transactions, (d) preparation of the payroll including accurate transactions with regard to deductions for retirement, taxes, insurance, bonds, etc., (e) management of residents' funds administered in trust by the institution, (f) the collection of accounts receivable (where appropriate), and (g) analysis of operating costs.
- (2) The head of this division may be the business manager, controller or chief accountant. He shall have had formal training in accounting and auditing with special emphasis on governmental accounting. In addition, he should have had at least three years of progressive experience in accounting or auditing with at least one year in a supervisory capacity and at least one year in the institution or related public service.
- (3) He should be assisted by accountants, account clerks, clerks and clerk-typists in sufficient numbers to assure the maximum support to the efforts of the care, treatment and training staffs.

c. Purchase, Supply and Property Control

- (1) The detailed functioning of this division will vary in different states depending upon the laws and regulations governing the nature and extent of central control. Accordingly this may be a separate function or a sub-division under the financial officer. In any case, it should include the following: (a) purchase or procurement section, (b) warehouse section, and (c) property control section.
- (2) Depending upon local policy the head of this division will be a purchasing agent, chief clerk or storekeeper. He should have demonstrated competence through several years of progressive experience in institutional or related work.
- (3) He should be assisted by sufficient members of clerks, stores clerks and equipment operators to maintain an efficient operation in keeping available supplies and equipment essential to the health, safety

and welfare of the residents and the accomplishment of the mission of the operating departments.

d. *Commissary or Canteen*

- (1) Many institutions will wish to establish a commissary or canteen (community store) for the purpose of providing an opportunity for residents to have a socializing experience as well as a place where purchases of items for personal needs and small luxuries can be obtained. This facility will also be a convenience for employees. In addition, the commissary will provide the opportunity for valuable training of residents as well as an opportunity to make a profit which should be used exclusively for the welfare and entertainment of the residents. Whether the commissary is operated as an integral part of the institution or more or less on a concession basis will depend on requirements in a particular state.
- (2) The commissary manager should be selected not only because of demonstrated competence in a business enterprise but also because of ability to supervise what is simultaneously a kind of recreational service and a vocational training area. Sufficient regular paid staff should be available, although there is provided here an opportunity to compensate resident trainees who will be expected to contribute to production.

e. *Institution Industries*

- (1) There are a number of services which an institution may provide which may be classified as institution industries. They may have a primary training function with production secondary. How they will be administered and how they relate to other services will depend upon the goals for them and on local policy. Among these services are the following:
 - (a) Barber Shop
 - (b) Beauty Shop
 - (c) Greenhouse
 - (d) Shoe Repair Shop
 - (e) Tailor Shop
 - (f) Upholstery Shop
 - (g) Furniture Repair Shop.
- (2) In each case the activity shall be supervised by a person who holds the proper license or certificate as required by law or has demonstrated competence at a level equal to that of the journeyman. If these activities are considered to have a primary training focus they may be supervised by individuals classified as vocational instructors who are responsible to the vocational training division.

f. *Communications (Mail Room and Switchboard)*

- (1) There will be in every institution some area which serves as a communications center. Often it serves also as a mail room or post

office for the institution. Whether this is a separate division or attached to the superintendent's office, the business office, or wherever will depend upon the size of the institution and local policy. Without doubt there will be a central switchboard which operates continuously. Such an operation should be headed by a chief operator (or clerk if this serves also as the mail room) and sufficient assistant operators to provide 24-hour a day, 7-day a week coverage. During the peak periods there may be required two people to provide adequate service.

- (2) Such persons shall be experienced in switchboard operation, emotionally stable, able to exercise sound judgment under pressure and capable of representing the institution to the public. A minimum of five people will be required to provide regular coverage plus a sixth person on call to fill in for vacations, sick leave, etc. The addition of the supervisor indicates the need for seven people.

g. Personnel Management

- (1) The development of a sound program of personnel management is basic to the procurement and retention of an adequate number of qualified, capable staff members. A central personnel office will ordinarily be a most effective agent in accomplishing this goal. The central personnel office should be responsible for: (a) employment, (b) induction, orientation and management training, (c) coordination of transfers, merit ratings and promotions, and (d) employee welfare services.
- (2) The personnel manager should be qualified by college training in personnel administration or psychology and three years of progressive experience in business, industry or governmental services or in an institution for the retarded. There should be one personnel employee for each 300 employees or major fraction thereof, plus necessary clerical assistance.

h. Dietary Service

- (1) The food served in an institution for the mentally retarded should be of high quality when procured and stored appropriately to assure the maintenance of quality. There should be varied kinds, adequate in amount and preparation which assures high palatability, proper caloric content and proper balance in proteins, fats and carbohydrates. The food should be attractively served at appropriate temperatures. Due consideration should be given to the fact that many of the residents will be growing children and many will have special needs because of physical handicaps. Furthermore, provision should be made for the serving of special diets when medically indicated. The food should be served insofar as possible in attractive surroundings in an unhurried, relaxed atmosphere, encouraging the development of acceptable table manners and eating habits.

- (2) Some institutions will establish the dietary service under medical responsibility while others will place it under the business administrator with the medical director being given responsibility for the health-nutritional aspects of food service.
- (3) The head of the dietary service should, if possible, be a trained dietitian with special qualifications permitting recognition as an administrative dietitian. If this is not possible then a food service administrator or manager with training and experience in hotel, restaurant or industrial food services may be employed. Such a person should always have at least one assistant directly responsible to him who is a trained dietitian functioning in the role of a therapeutic dietitian. This employee should have the responsibility of continuous evaluation of the food program from the nutritional standpoint and also assume responsibility for the supervision of the preparation of the special diets.
- (4) The organization and staffing of the dietary department will depend upon many factors such as the size of the population, whether there is a single central food preparation center and the number and location of decentralized kitchens and dining rooms. Assuming at least centralized preparation of food it is suggested that there will be required 2.5 employees for each 10,000 rations. Cooks, bakers, food service supervisors and food service workers will be required.*

i. *Engineering and General Maintenance*

- (1) This division is generally responsible for the overall management of the physical plant, grounds, utilities, fire protection, safety and security, and the generation of heat and power. Wide variations will exist depending upon the location of the institution, the availability of utilities and existing policy regarding purchase of such services.
- (2) In most institutions the size and complexity of needed services will be such as to require a plant maintenance engineer (building and maintenance superintendent) to head this division who is highly competent with extensive experience in general building construction, plant maintenance and power plant engineering. It is highly desirable that the head of this division have at least three years of progressive experience in institutional engineering and maintenance. A knowledge of the special problems involved in the severe treatment encountered by building and utilities by children and especially disturbed people is mandatory to the job.
- (3) The chief engineer should have a first assistant with similar quali-

* The method of computing the dietary personnel is: One ration is equal to three meals a day. In an institution with an average daily census of 2,000 there would be served annually 2000×365 or 730,000 rations. $730,000$ is divided by $10,000$ equals 73×2.5 equals 182 employees required.
The formula:

$$\frac{\text{average daily census} \times 365}{10,000} \times 2.5 = \text{employees required}$$

fications plus section heads for each of the major subdivisions under his supervision.

- (4) If a power plant is operated, this section should be headed by a licensed stationary engineer with assistant engineers and firemen who are licensed according to state law. In addition, maintenance repairmen and laborers will be required to maintain the power plant in efficient operation.
- (5) Depending upon the organization structure and the size of the institution other sections which may come under the supervision of the chief engineer are: (a) auto mechanics, (b) transportation, (c) ground's care, (d) sewage disposal plant operation, (e) fire, safety and protection services, (f) farm and gardens, and (g) general building maintenance and construction which includes all of the building trades. In this section a suggested standard is 1.3 persons for each 10,000 square feet of space serviced.
- (6) All of the above sections shall be staffed with personnel who have competence at least equal to that of persons in similar positions in private industry or other governmental agencies (such as the Veteran's Administration or Post Office Department). The personnel should be sufficient in number so that the rendering of optimum service does not depend upon the labors of the residents who may be assigned as part of a vocational training program or industrial therapy. Such assignments should *always* be made within the framework of this philosophy. It is important to provide financial remuneration for those residents who perform useful and productive work which is not primarily for training purposes.

j. *Housekeeping (including Sewing Room)*

- (1) There should be a specific division responsible for housekeeping services to assure proper routine daily housekeeping and periodic general cleaning: to store, control and dispense housekeeping supplies and to supervise the marking, distribution, mending and salvage of linens. To the extent that it is possible, especially on wards where young children, the severely handicapped and the elderly reside, housekeeping duties should be taken over by housekeeping staff employees to relieve resident care workers so that they may concentrate on working directly with the resident.
- (2) The head of the housekeeping division shall have several years of progressive experience in institutional, hotel or hospital housekeeping. It will be helpful if the head housekeeper has taken formal training in some of the several short courses or vocational schools which are available. Particularly important are experience and training in supervision and management.
- (3) The assistant to the head housekeeper shall have experience and training comparable to the latter. Custodial workers or janitors, domestic workers and laborers shall be available according to the

following formula: 1.2 employees for each 10,000 sq. ft. of wards, offices and other units established as the responsibility of housekeeping staff.

k. *Laundry*

- (1) Most larger institutions will operate their own laundry service because of convenience and for economic reasons. The laundry service should be so organized and managed that the daily clothing and linen needs of the residents can be met without delay and without excessive loss of or damage to clothing. The capacity of the laundry will have to take into account the numbers and types of residents served. In the case of untidy residents bathing several times daily, several changes of bed linen may be necessary.
- (2) The laundry manager should have had systematic training in the technical processes involved in laundry operation and in the routine maintenance of laundry equipment. Formal training in supervision and management should have been achieved. It is desirable that the laundry manager have had at least three years of progressive experience in large institutional or commercial laundry operation with preferably one year in an institution for the mentally retarded.
- (3) A first assistant, two or more supervisors and laundry workers of several levels should be employed so that production will not be dependent on resident labor. It is suggested that there be one laundry worker for each 5,000 pounds of work per month, exclusive of supervision.

5. *Resident Care*

a. *General*

The care and supervision of the residents in the cottages, dormitories or other living units will be the responsibility of the largest single group of employees in the institution. This responsibility will ordinarily be carried out at the level of the cottage, ward or other housing units by personnel who must fulfill, at least to some extent, the role of parent.

b. *Administration and Supervision*

The resident care program will be administered differently in different institutions depending upon whether it is the policy of the institution to have a nursing service administration plan of organization or a cottage life plan of organization.

If a nursing organization is employed, the head of resident care should be a registered nurse with advanced preparation, preferably to a Masters degree, and experience in maternal and child care and/or psychiatric nursing and in administration. Such preparation should include a broad knowledge of nursing, growth and development, human relations and provide an understanding of physical, psychological and social

problems. The director of nursing should have at least three years of progressive experience in an institution for the mentally retarded or related institutions such as mental hospitals or children's institutions. If a cottage life organization is used the head of resident care shall have college training, preferably to the level of a Masters degree in social work, education, psychology or some related professional training in the behavioral science. Such training should include training in administration and supervision and a broad knowledge of the principles of growth and development, human relations, and understanding of physical, psychological and social problems. He should have at least three years of progressive experience in an institution for the mentally retarded or related institutions such as mental hospitals or children's institutions.

The director of resident care shall have several assistants depending upon the size and structure of the organization. There should be at least one assistant for administration for each of the three shifts with appropriate relief with possibly two or more assistants for the daytime shift to provide for closer contact with the supervisory and resident care staff at the level of the cottage or living unit. It would be desirable that there be also an assistant director for training to plan, organize and conduct a continuous in-service training program for the resident care staff, most of whom will have had limited training prior to employment. The training of the assistant directors should be comparable to that of the director.

If the institution is sufficiently large it may be subdivided into two or more sections based upon sex, age of residents, type of care needed or because of geographical considerations. Depending upon the size, it may be desirable to have either assistant directors or area supervisors serving as administrative heads of these sections with respect to resident care administration. There shall be sufficient numbers of resident care supervisory personnel for all shifts to assure adequate supervision of personnel assigned to cottages, dormitories or wards.

c. *Cottage or Ward Supervisory Personnel (Cottage Supervisors, Matrons, Charge Aides or Charge Attendants)*

When possible supervisory personnel should be recruited who have had a broad general education with some preparation in fields of teaching, social sciences, psychology, nursing, counseling or related fields and experience in working with groups, teaching, and counseling, in care of residents and work with children and parents. When supervisory personnel have not had such educational preparation and experience on a pre-service basis, such preparation and supervised experience should be provided on an inservice basis. There should be supplemental education and experience in supervisory and administrative skills.

d. *Resident Care Personnel (Cottage Parents, Psychiatric Aides, Attendants and Child-Care Workers)*

Basic requirements for all resident care personnel are demonstrated ability to work with children, to meet physical, psychological and social developmental needs, and to work effectively with other personnel and parents. They should have warm understanding and consistently positive attitudes in their relationships. They should have such supplemental training or experience as needed in helping them to direct, counsel and supervise children and meet basic physical, psychological and social needs.

Resident care personnel shall meet basic educational requirements established by the institution. They shall have the ability to read, write and comprehend written and oral instructions, be able to communicate with residents, personnel and parents, have positive attitudes toward children, and ability to work effectively with others, and such other qualifications as deemed necessary by the institution for the level of assignment. Efforts should be made to recruit persons with at least a high school education and evidence of satisfactory personal life adjustment.

e. *Numbers of Personnel*

There shall be sufficient numbers of personnel assigned to direct care of residents to maintain standards for a safe, healthful and constructive environment and to promote the physical, psychological and social growth of the residents in the setting of the living unit and its environs.

The number of resident care personnel necessary to accomplish the goal of promoting optimum development of the residents in a safe and healthful environment will vary according to the age, physical condition, intellectual level and emotional stability of the residents. The assumption is made that the care of residents will not be the responsibility of other more capable residents except as it may be incidental to planned, systematic training for the latter. To some extent also the number of employees required will be dependent upon the number of residents in a particular living unit.

Suggested ratios for resident care personnel are indicated on the accompanying chart. Six broad categories of residents are described, recognizing that age, physical capacity, mental level, emotional stability and behavior are criteria which determine the extent of adult care and supervision which are required. These ratios are based upon a 5-day, 40-hour week with 12 working days vacation, 10 holidays and 10 days of sick leave.*

* It is suggested that the most logical approach to the determination of the numbers of resident care employees needed is to consider how many residents of a particular type or with particular needs can be properly supervised and cared for by one employee on a given shift. Accordingly on the chart the numbers indicated refer to the suggested reasonable "caseload" for a single employee. The number of employees needed for a given shift is determined by dividing the total number of residents in the living unit by the indicated number cared for by one employee. This represents the basic complement for that ward for that shift. To this must be added necessary numbers for relief coverage including regular days off, vacation, holidays and sick leave. To keep an employee on duty in each position 7 days a week requires 1.6 employees. Thus the basic complement must

STANDARDS FOR STATE INSTITUTIONS FOR MENTALLY RETARDED

RATIOS FOR RESIDENT CARE PERSONNEL ARE SUGGESTED IN ACCORDANCE WITH SIX BROAD CATEGORIES WHICH ARE DETAILED BELOW.

| Categories of Residents in Accordance with Needs or Special Living Units | 1st Shift | 2nd Shift | 3rd Shift | Overall Ratio for 7 Day, 24 Hr. Coverage Including All Relief |
|--|-----------|-----------|-----------|---|
| <i>Category I</i> | | | | |
| Medical and Surgical Wards | 1:4 | 1:5 | 1:10 | 1: 1.15 |
| <i>Category II</i> | | | | |
| A. Admission wards or buildings | 1:5 | 1:7 | 1:15 | 1: 1.6 |
| B. Special Treatment Units | | | | |
| C. Infants and Children up to 6 | | | | |
| D. Profoundly and Severely Handicapped. | | | | |
| <i>Category III</i> | | | | |
| A. Children from 6 to Puberty not in I & II | 1:7 | 1:8 | 1:30 | 1: 2.2 |
| B. Moderately Physically Handicapped | | | | |
| C. Adolescents Needing considerable Adult Guidance & Supervision. | | | | |
| <i>Category IV</i> | | | | |
| A. Residents in late ado- lescence or adulthood who are purposely aggressive, assaultive or security risks | 1:10 | 1:15 | 1:15 | 1: 2.7 |
| B. Residents who manifest hyperactive "Psychotic- like" behavior with impulsive assaultive behavior. | | | | |
| <i>Category V</i> | | | | |
| A. Adults and Adolescents in need of habit training. | 1:10 | 1:15 | 1:30 | 1: 3.1 |
| <i>Category VI</i> | | | | |
| A. Adults who are stable, able to do ward work or work in sheltered activities | 1:15 | 1:15 | 1:30 | 1: 3.8 |
| B. Residents in Vocational Training Programs being prepared for community placement. | | | | |

be multiplied by 1.6 to get the appropriate number of employees. As an example a ward housing 30 residents of category II would require 19 employees to assure that there would always be 6 on the 1st shift, 4 on the 2nd shift and 2 on the 3rd shift. This number can be translated into an overall ratio as is demonstrated in column 4.

The approach used to arrive at the figure of 1.6 is as follows: To keep one position filled 365 days a year for each eight hours multiply 8×365 , giving 2920 man hours per year required: on the basis of a 40 hour week an employee will provide 40×52 or 2080 man hours per year, less the number of days vacation, holidays and sick time permitted or utilized. Assuming an average of 12 vacation days a year, 10 holidays and 10 sick days a total of 276 hours of service would be lost. Subtracting 276 from 2080 results in 1804 hours of service by a single employee. Dividing 2920 (the total hours required to keep the post filled) by 1804 gives a figure of 1.6.

6. Medical and Health Care

a. Medical Staff

The medical and health care program shall be under the supervision of a staff of qualified physicians headed by a medical director (or chief of the Medical and Health Service). He shall be a competent physician with demonstrated supervisory ability. It will be advantageous if he has completed residency and post-graduate training and experience requirements making him eligible for certification in pediatrics or internal medicine.

The staff physicians should be licensed and qualified to practice in the state of residence and manifest an interest in mental retardation.

The number of staff physicians will vary depending upon the size of the institution, the types of residents served and the activity with regard to admissions, transfers, placements, etc. A general formula is suggested as follows:

| | |
|----------|-------|
| Profound | 1:200 |
| Severe | 1:200 |
| Moderate | 1:250 |
| Mild | 1:350 |

In addition to the number required for the general medical and health care of the resident population as above, an additional physician will probably be required for each 400 annual admissions.

Consultant Physicians

Unless the full-time medical staff includes individuals with appropriate training and/or experience, the following specialties of medicine should be represented by consultant physicians:

- (1) Pediatrics
- (2) Psychiatry including Child Psychiatry
- (3) Electroencephalography
- (4) Neurology
- (5) Neurosurgery
- (6) Orthopedic Surgery
- (7) Physical Medicine and Rehabilitation
- (8) Internal Medicine
- (9) General Surgery
- (10) Anesthesiology
- (11) Ophthalmology
- (12) Otorhinolaryngology
- (13) Radiology
- (14) Pathology.

These consultants should have achieved recognition as specialists by the medical community or certified by the appropriate specialty board or eligible for such certification.

They should make regular visits to the institution providing consulta-

tion to the attending or resident staff, doing surgery, conducting clinics or ward rounds and contributing to the medical research work of the institution.

The larger general-purpose institutions will probably find it advantageous or necessary to have the service of one or more full-time specialists in pediatrics, neurology and psychiatry.

In institutions organized essentially as residential training schools a psychiatric service either as a part of the medical department or, preferably, functioning as a separate department is indicated by the nature of the complex bio-psycho-social problems encountered. Psychiatric evaluations, consultation to other staff members, direct psychotherapy and psychotherapy supervision are functions which can best be carried out by qualified psychiatric physicians. Such physicians should have completed formal psychiatric training including child psychiatry and be eligible for broad certification and preferably certified. It is suggested that one psychiatrist can accomplish 20-25 psychiatric evaluations a week or carry a caseload of 25-30 residents in individual therapy with the related recording, reporting and participation in case conferences.

Some institutions will be structured similar to mental hospitals in which ward, cottage or building physicians function in a dual role providing routine general medical care and health supervision and as the ward psychiatrist who coordinates the residents treatment program. The physician functioning in this capacity should have adequate training and experience in general medicine plus psychiatric training or extensive experience in an institution for the mentally retarded with supervision by a fully trained psychiatrist. The following ratios are suggested for physicians in this type of organization:

| | |
|-----------------------|-------|
| Admission Ward | 1:40 |
| Medical Surgical Ward | 1:40 |
| Intensive Treatment | 1:30 |
| Prolonged Care | |
| Mild and Borderline | 1:75 |
| Moderate | 1:100 |
| Severe | 1:150 |
| Profound | 1:150 |

b. *Nursing Staff*

If the institution is not structured with an overall nursing administrative organization, the nursing staff will no doubt be limited to the hospital, dispensary clinics and general health services. In such case the nursing director or supervisor will probably be administratively responsible to the medical director.

The nursing director or supervisor shall be a registered nurse with demonstrated technical competence and leadership ability. She shall have had training and experience in administration and supervision and three years of progressive experience in hospital or institutional

nursing with preferably at least one year's experience in an institution for mentally retarded.

The medical-surgical hospital (or ward) shall be staffed by registered nurses, licensed practical nurses and/or trained attendants with the following ratios:

| <u>1st shift</u> | <u>2nd shift</u> | <u>3rd shift</u> |
|------------------|------------------|------------------|
| 1:4 | 1:5 | 1:10 |

These figures refer to the actual number who should be on duty at all times on the respective shifts. Additional personnel will be needed for relief of the basic complement for days off, holidays, sickness, etc.

For each separate ward or nursing unit or group of 20 patients there should be a designated ward charge who shall be a registered nurse with demonstrated supervisory ability.

There shall be nursing service personnel assigned to the cottage or building nursing visitation service, to dispensary clinics, and to central supply, in sufficient numbers to meet the appropriate needs of these services.

c. *Dental Service*

Dental Service shall be provided to furnish initial examination at admission, to provide regular semi-annual re-examinations with prophylactic and hygiene services, to provide emergency dental care as needed and to provide corrective dentistry including extractions, fillings and prosthetic work as needed. The dental staff should also assume responsibility for instructing resident care staff in proper daily oral hygiene.

There should be one full-time licensed dentist for each 750 residents and one dental hygienist for each 500 residents.

d. *Chiropody Service*

Depending upon the size of the institution, the types of residents served and the size and interests of the medical staff, it may be found desirable to have a chiropody service. Such service should provide consultation and foot treatment service upon the referral of the general medical staff. Such a service can be provided by a part-time staff chiropodist or a visiting consultant.

e. *Pharmacy*

Whether a regular pharmacy or only a drug room or other drug storage facility is provided will depend upon the size of the institution and to some extent the types of residents served. Most of the larger, general purpose institutions will have need for a pharmacy which should be headed by a registered pharmacist, preferably full-time. If, because of size of the institution or unavailability, it is not feasible to have a full-time pharmacist, part-time service should be available. There should

be an assistant to the pharmacist or a person available in the absence of the pharmacist who is qualified to be certificated as an apprentice. In the event there is no pharmacist available the supervision of the pharmacy or drug storage area should be the responsibility of the medical director.

f. *Physical Medicine Service*

Those institutions serving significant numbers of physically handicapped residents or operating a large medical-surgical service should provide a physical medicine program under the supervision of a qualified physiatrist as director or consultant. Registered physical therapists and registered occupational therapists and trained assistants shall be provided in accordance with the following ratios:

- 1 Registered Physical Therapist for each daily caseload of 16 residents.
- 1 Trained Physical Therapy Aide for each daily caseload of 8 residents.
- 1 Registered Occupational Therapist for each daily caseload of 16 residents.
- 1 Trained Occupational Therapy Aide for each daily caseload of 8 residents.

g. *Speech and Hearing Service*

Because of the high incidence of speech disorders among the mentally retarded a speech and hearing service is required. This service may be administered as a part of the education department or as a part of the medical and health service. The speech and hearing clinic will require the services of a speech pathologist and an audiologist unless a single person can be found who has adequate skills in both areas. The consultant otologist will be helpful in providing consultation service to this clinic.

If administered as a part of the education department, speech and hearing therapists should be certified by the State Department of Education and hold at least basic certification as prescribed by the American Speech and Hearing Association. If administered as a part of medical and health services, therapists should meet the educational requirements proposed by the appropriate departments of the individual states and hold at least "Basic Certification" by the American Speech and Hearing Association. The supervisor in this area, should have at least "Advanced Certification," preferably "Sponsor Certification," by the American Speech and Hearing Association. In addition he should have had at least one year of experience working with the mentally retarded.

It is suggested that there be one speech and hearing person for each unit of 400 residents or any major fraction thereof in the general purpose institution.

h. *Clinical Laboratory*

If the institution operates its own medical and health program a hospital unit clinical laboratory service will be required. Insofar as possible

the hospital unit should meet the requirements of the American Hospital Association for accreditation. Service in hematology, chemistry and bacteriology should be provided with a physician, preferably a qualified pathologist, having overall supervision. The laboratory director should be fully trained in clinical laboratory technique with a college degree and have achieved registration in the American Society of Clinical Pathologists. Other laboratory technicians shall be registered or capable of registration by the American Medical Technologists Society.

There should be one trained technician for each 7,200 procedures accomplished annually.

i. *X-Ray Laboratory*

The X-Ray Laboratory should meet the standards of the American Hospital Association with a physician, preferably a qualified radiologist, having overall supervisory responsibility. Routine admission chest films, regular diagnostic studies and annual chest surveys of all residents and employees should be accomplished by this service. The supervisor should have demonstrated competence as reflected in registration by the American Registry of X-Ray Technicians.

There should be one technician for each 2,000 procedures accomplished annually, assuming that clerical assistance will be provided.

j. *Electroencephalographic Laboratory*

For complete diagnostic work most institutions for the retarded will find it extremely helpful to have an electroencephalographic laboratory. Such a service will require a qualified, experienced physician to serve as electroencephalographer. If the full-time staff does not include a person with these skills, a visiting consultant will be required. There shall be a chief technician who has demonstrated competence in obtaining readable tracings especially from children and uncooperative patients. Adequate understanding of the instrument used sufficient to detect and correct minor mechanical failures is necessary.

Because of the difficulties encountered in obtaining good tracings with the mentally retarded it is suggested that the average technician will be able to do about 400 tracings a year. If there is a single technician, assistance will often be required from the nursing service in the management of the patient.

k. *Clinical Records*

A central record room should be established in which permanent records are maintained on each resident.

The record room shall be supervised by a registered record librarian or a person with equivalent training and experience. The record librarian shall be assisted by sufficient well-trained staff to assure that current data is placed in the record and the appropriate required statistical reports are made.

It is suggested that there be one record room employee for each 250 annual admissions and one for each 500 residents or any sizable fraction thereof with appropriate supervision.

1. *Stenographic Service*

There should be maintained either separately or under the supervision of the record librarian a stenographic service (or pool) for the purpose of placing in the clinical record of each resident the data dictated by or written by the staff members who work with the residents.

The members of the stenographic service shall be clerk-stenographers or clerk-typists who are competent by reason of training and/or experience.

It is suggested that there be one stenographic service employee for each four full-time professional clinical workers with appropriate supervision.

7. *Chaplaincy Service*

Chaplains should be fully ordained clergymen. They should have both the A.B. and B.D. degree or their equivalent in semester hours of college and graduate theological study. They shall be in good standing in their church or denomination, and shall have the endorsement of the appropriate authorities of their ecclesiastical organization for this work. In addition, they shall have had pastoral experience and have satisfactorily completed a period of specialized training and/or actual experience in the institutional ministry as approved by a recognized organization. They should have conspicuous ability to work cooperatively with their colleagues, to exercise initiative, tact, patience and good judgment in dealing with people of all classes and types; ability to earn the respect and esteem of others; intellectual and personal integrity and emotional stability. It is desirable that they also have completed acceptable clinical pastoral training and in addition training in child development, child psychology and educational methods.

There should be one full-time chaplain for each 500 residents or substantial fraction thereof in a particular faith group.

8. *Education and Training*

The director of the department shall have completed training to at least the Masters level with particular emphasis on school administration, educational psychology and special education for exceptional children. He should have had at least three years of supervisory and administrative experience prior to assuming the duties as head of the department. It would be preferable if at last one year of that service were in an institution for the mentally retarded. He should have or be capable of obtaining certification as a principal or superintendent.

Depending upon the size of the school program and the type of organization structure the director of education and training should have two or more first assistants. One, who may be called principal, will head the

academic program. The other will supervise the vocational or occupational training program. Both assistants should be certified teachers with training and experience in supervision and administration qualifying the individual for certification as a principal. It is desirable if the supervisor of vocational training has also had training in vocational education. In some institutions the latter service will be called industrial therapy and will not function under the director of education and training. In still others there will be other functions assigned to this department such as occupational therapy, recreation, etc.

Classroom teachers shall all have teaching certificates valid for teaching elementary subjects and special education classes and be in sufficient numbers so that all of the residents capable of special education may profit from such experience. Ratios of teachers to resident population between six and twenty-one years of age and to special class units for the different levels of retardation:*

In addition, teachers shall be provided in art, home economics, music, industrial arts, health and physical education in such numbers that all children attending the school program shall be able to participate in these programs.

The school shall provide a library which meets the standards of the education certifying body and is in charge of a qualified librarian.

In the vocational training program some residents will be assigned for training to regular production employees whose main responsibility is not training. In these instances it is the responsibility of the vocational training staff to provide functional supervision to the regular production workers in relation to their training activities. Certain institution services or industries may be operated by trained vocational instructors with a primary function of providing training with secondary production considerations. In this type of organization the vocational instructors shall have demonstrated competence in the technical aspects of the trade to the level equal to that of a journeyman and also in practical training and teaching on the job. It is suggested that each vocational instructor have responsibility for not more than ten trainees for this type of instruction.

* The above is based upon measured intelligence levels of the AAMD classification system. The IQ levels (Revised Stanford-Binet Tests of Intelligence Forms L and M) are Profound IQ's below 20; Severe IQ's 20 to 35; Moderate IQ's 36 to 51; Mild IQ's 52 to 67; and Borderline IQ's 68 to 83. The ratios of teachers to resident population, ages six to twenty-one, were determined as follows: (1) It was assumed that the profoundly retarded may profit from therapeutic programs but not in special education units. (2) It was assumed approximately 20 per cent (eight out of forty) in the upper levels of the severely retarded may profit from instruction in special education units. This would provide a teacher for consultation and for systematic instruction for each unit of 40 in the severely retarded population. (3) It was assumed that approximately two-thirds of the moderately retarded (twelve out of eighteen) would profit from systematic instruction in special education units. (4) It was assumed that most of the mildly retarded or borderline would profit from systematic instruction in special educational units. Ratios of teachers to resident population between six and twenty-one years of age and to special class units for the different levels of retardation:

| | Profound | Severe | Moderate | Mild & Borderline |
|-----------------------------|----------|--------|----------|----------------------|
| Resident population | 0 | 1:40 | 1:18 | 1:15 |
| Size of special class units | 0 | 6-8 | 10-12 | 15 |

9. *Psychological Services*

The psychology department shall be administered by a chief or supervising psychologist with a doctorate in psychology and specialization in clinical psychology, who, in addition to meeting the qualifications of staff members, has had at least three years experience as a staff member or as an administrator, or combination of the two. In facilities where the number of psychologists is less than six, the chief psychologist can assume all supervisory and administrative functions but should designate a staff member as an assistant chief. In addition to the assistant chief there should be an additional position of supervisor for every six staff members or major fraction thereof. If no such position is in existence a staff member should be designated as acting supervisor wherever there are six staff members for him to supervise.

Staff members should be fully trained to at least the level of the Masters degree including an academically sponsored internship in clinical psychology and preferably with post-masters training up to and including the Ph.D.

The number of staff psychologists required will depend upon the use of the discipline, the size and nature of the resident population and the average number of annual admissions.

The following separate services are indicated with recommended numbers of psychologists based upon the volume of services rendered or the number of residents served in the different levels of retardation.

a. *Pre-Admission Service*

One psychologist for each 200 annual pre-admission referrals studied.

b. *Admission Service*

One psychologist for each 200 annual admissions.

c. *Special Treatment Service including Psychotherapy*

One psychologist for each caseload of 25 residents.

d. *Continued Care Units*

Profound

1:400

Severe

1:300

Moderate

1:200

Mild and Borderline

1:100

e. *After Care*

One psychologist for each 200 complete evaluations required or 1 psychologist for each 30 intensive therapy cases served.

f. *Research*

Number determined by the number of hours of psychological service in research which the institution establishes as its policy based upon a 40-hour week.

g. *Training of Personnel*

Number determined by the actual hours of teaching and preparation expected from the psychologist in the training program for personnel.

10. *Social Service*

The director or chief of the social service department shall have completed graduate training, including field instruction, to the level of at least the Masters degree. The professional education should preferably have been received in one of the graduate schools of social work accredited by the Commission on Accreditation of the Council of Social Work Education. He shall also have had at least three years of experience in supervision and administration with preferably one year in a residential institution for the mentally retarded. There shall be provided individuals with comparable training and experience to serve as assistant director of the department and/or as a supervisor for each complement of six staff case workers.

Staff social workers or case workers shall have completed training in an accredited school of social work or have equivalent supervised experience. The number of case workers required will depend to a great extent on the type of institution, total size and activity with regard to admissions and placements.

The following types of service or functions are described with the recommended numbers:

a. *Pre-Admission Services:*

In pre-admission, the social worker helps applicants, their families and professional persons working with these applicants and/or their families whether or not admission to the institution is in the best interest of the applicant and whether or not they meet the eligibility requirements for eventual admission to the facility. With this beginning help, the family may decide that they are able and want to use the home and community resources and may not seek admission.

Staff requirements: One social worker for every 100 to 150 annual applications depending upon the function of the pre-admission service and the size of the state or geographical area covered.

b. *Admission Service*

The social worker offers a casework service to the patient and his family or others in order to actualize the reality of the separating experience occurring at the time of admission.

Adequate psycho-social histories are also required and should be obtained to facilitate diagnostic and program plans for the individual. The social worker should be involved with the family and individual at least four weeks before admission and should continue to work with the individual through admission to the facility and for at least an additional six weeks or longer, depending upon his adjustment. Thus the social service department should have primary responsibility in working with families both in orientation and in helping them adjust to the admission process. This provides an on-going service to preserve the intra-familial relationships and to prepare the resident and family for the goal of eventual community placement whenever possible. Con-

sequently, the social worker should be the resident-family-facility-community link in all aspects of care.

Staff requirements: One social worker for every 150 annual admissions.

c. *Resident Social Service*

Psychotherapy with the resident assists many with emotional and behavioral problems which may lead to their final rehabilitation to the community.

In large facilities, adequate social service staff should be employed to function as a member of a hall, ward or cottage team.

Staff requirements: One social worker for every 100 residents, including direct treatment caseload of 25 to 35 residents at a given time.

d. *Placement Service (Trial Visit, Family Care, Wage, Etc.)*

The development of employment and home placement situations for the return of the resident to the community is a demanding job which includes specific knowledge and training, and the handling of many emergency situations involving the employed resident and the community.

Staff requirements: One social worker for 30 to 50 residents placed in community training or employment situations, depending upon the size of the state or geographical area covered.

One social worker for every 50 to 75 residents placed in foster homes, or their own home situations, depending upon the size of the state or the geographical area covered.

11. *Recreation*

The recreational director should have college training in group work, physical education or community recreation or some related field preferably to the level of a Masters degree with at least three years' administrative and supervisory experience, preferably with at least one year of experience in an institution for the mentally retarded. The recreation workers or recreational leaders should have completed training in one of the above fields or in the social sciences with field experience in group work or recreation. Recreation aides without complete college training may be employed provided they are given thorough in-service training.

The following ratios for recreation workers or leaders, exclusive of supervision, are recommended for different types of residents:

| <u>Profound</u> | <u>Severe</u> | <u>Moderate</u> | <u>Mild and Borderline</u> |
|-----------------|---------------|-----------------|----------------------------|
| 1:300 | 1:250 | 1:150 | 1:100 |

12. *Occupational Therapy*

Occupational therapy is defined as medically prescribed and professionally guided physical or mental activity devised to treat specific disorders or disabilities. In mental retardation occupational therapy may be especially valuable in the treatment of residents manifesting physical disabilities, emotional disturbances and the wide variety of perceptual handicaps

which are seen, particularly in the younger, more severely retarded resident.

In many institutions occupational therapy will include the following services; industrial therapy, music therapy, bibliotherapy and even recreation or recreational therapy. In still others all of the above mentioned services will be constituted as separate departments which are grouped together and called rehabilitation services, adjunctive therapies or activities therapies under the general supervision of a director or coordinator. In some institutions the combined services or the individual "therapies" will come under the administrative direction of the clinical director; in others under the direction of the director of education and training.

Whatever the organizational plan, it is suggested that there is considerable rationale for the existence of at least two relatively distinct functions: The first of these is recreation which may be organized along the lines of community recreation. The second is a program of "therapies" which implies that medically prescribed and clinically oriented physical and mental activity will be employed to treat specific disorders and disabilities.

It is submitted, therefore, that occupational therapy should be established as a separate and independent discipline embracing all of the "therapies" described above.

The director or supervisor of occupational therapy shall be a qualified graduate of a school accredited by the Council on Medical Education and Hospitals of the American Medical Association and shall be registered by the American Occupational Therapy Association. He should have three years of progressive experience in an institution for the mentally retarded or related institutions and have demonstrated competence in supervision and administration.

Staff occupational therapists shall have training similar to that of the director, with the appropriate registration requirements having been met. Occupational therapy aides shall be at least high school graduates, with some college training preferably, and shall be provided specific in-service training. They should work under the supervision of a registered occupational therapist.

Occupational therapists and occupational therapy aides should be provided in sufficient numbers to meet the needs of the residents who have specific disabilities for which the services are prescribed. The following ratios are recommended:

One registered occupational therapist for each daily caseload of 24 residents (except in the case of physical disabilities where a caseload of 16 is recommended).

One occupational therapy aide for each daily caseload of 16 residents (except in the case of physical disabilities where a caseload of 8 is recommended).

13. *Volunteer Services*

The well-trained and highly motivated volunteer can play a very important role in the institution for the mentally retarded. The individual volunteer can complement the services provided by nearly every department or division in the institution. Volunteer groups can be most helpful in mobilizing the community to provide material support in terms of money, supplies and equipment; to supplement the institution's resources; as well as providing for parties and special activities both within and outside the institution. Above all, the volunteer program can be the source of a meaningful contact for the resident with the outside community, can provide encouragement and support to the efforts of the staff, and can provide an exceedingly important opportunity to further public understanding of the problems and needs of the mentally retarded.

It is important that there be a full-time staff member to supervise and coordinate the selection, training and utilization of volunteers. The coordinator of volunteers should be appointed on the basis of demonstrated competence to provide the necessary guidance to this important effort. While there appears to be no formal training program which specifically prepares for this position, college training in the social sciences with emphasis upon community organization, adult education and similar fields would offer the best preparation. Three years of experience in an institution for the mentally retarded would be highly desirable. Some of the experience may be obtained as a volunteer, but it is important that the appointee have at least one year's experience as a paid staff member.

14. *Research*

Research in all aspects of mental retardation and research in administrative procedures should be undertaken by institutions for the retarded. There should be funds specifically budgeted for personnel, equipment and supplies which are separate and apart from operating funds. However, personnel in operating departments should be encouraged to participate in research programs and maintain a healthy spirit of inquiry with respect to their day-by-day work.

It will be advantageous if there is available a research director or coordinator who is fully trained in research design and methodology who can provide technical consultation to those persons engaged in research in the various institution departments. Adequate clerical and statistical service should be made available.

Subsection II. STANDARDS ON TRAINING AND STAFF DEVELOPMENT

A. *Minimal Standards*

1. *General*

- a. Continuous training and staff development are necessary to assure that maximum contributions is made by each employee to the care, treatment and training of residents.

- b. Training and staff development shall be the responsibility of a training director who shall report to the chief executive officer or one of his first assistants.
- c. While training and staff development shall be focused primarily upon the improvement of services to the residents by employees efforts should also be made to contribute to the professional development of individuals not a part of the institution staff.

2. *Specific*

a. *Orientation Training*

Orientation training shall be provided for all employees to acquaint them with the history, purposes, philosophy and organization structure of the institution. This will also involve helping the new employee learn to know his place in the organization.

b. *Induction Training*

Induction training shall be provided for each new employee so that his anxieties will be allayed and his initial lack of skill will not work to the detriment of the residents.

c. *Skill Training*

Skill training shall be provided for all employees who have not already achieved reasonable competence demonstrated in other similar or related work. This will be particularly important for those employees working directly with the residents as attendants or cottage parents who will not have had the opportunity for formal training such as is available to the professional disciplines. It may also involve specific training for all employees with respect to the special problems of the mentally retarded.

d. *Supervisory and Management Training*

Training in supervision and the principles of management shall be provided for all employees filling supervisory or management positions or for candidates for promotion to such positions. Such training shall be concentrated on the development of the leadership role, proficiency in communications and in the human relations aspects of the supervisory or administrative role. Included here also should be periodic refresher training for all administrative and supervising personnel relating to the implementation of new policies and procedures.

e. *Training in Inter-disciplinary Relationships*

Institutions generally will discover that they function most effectively when all the disciplines involved in resident care, treatment and training are integrated in a cooperative arrangement sometimes described by the term "team." Teamwork does not occur by chance or even by administrative fiat. Meetings at the level of wards, cottages, or buildings of personnel from the various involved disciplines, called team meetings, can be effective instruments for achieving inter-departmental cooperation. Such groups must be properly led and related in a clear

cut manner to the administration. Such group meetings provide an excellent opportunity for training of all the members of the groups through focusing on the day by day problems of the residents as individuals and as a group. It is highly recommended that this approach be considered and viewed as an important and effective training device.

f. *Departmental Training*

Each major functional unit of the institution will need to constantly review its technical and functional competencies in the light of changing goals, new responsibilities and increased knowledge. Through lectures, seminars, discussion groups, opportunities to visit other institutions and observe programs first hand and supervision, on-going in-service education shall be provided for all employees in each department.

g. *Advanced Professional Training*

It is incumbent upon the institution for the retarded to further the knowledge about mental retardation among all professional groups. Not only will this aid in the recruitment of staff for the institution, but it will also help assure that professionals who work in community agencies or practice privately will be more competent to deal with the problems of the retarded as they encounter them. Fieldwork placements, internships, residencies and fellowships for physicians (in the several specialties), nurses, child care workers, psychologists, social workers, teachers, chaplains, therapists (occupational, physical, etc.) and recreation workers would all provide valuable opportunities to broaden interest in and competence with the mentally retarded. At all times the primary need of these trainees to increase their knowledge and understanding and to improve their skills in practice rather than constitute a "cheap labor force" should be of paramount concern to the administration.

SECTION V

STANDARDS ON PHYSICAL PLANT

A. *Minimal Standards*

1. *General*

- a. The physical plant shall be so located, constructed, and equipped as to maximize the safety, health, and comfort of the residents and staff.
 - (1) The grounds should be readily accessible, free from any and all obstructions to sunlight, well drained, and generally conducive to maintaining the highest level of sanitary and safety conditions.
 - (2) A great amount of emphasis should be evident in the general beautification of grounds.
 - (3) Adequate roads and ample parking space should be accessible to all buildings.
- b. The physical plant should be so located, constructed, and equipped, and its basic design should include the essential components so functionally arranged, as to provide maximum opportunities for carrying out those philosophies and program goals set forth in Section I, Subsections I and II.
- c. The size, location, and type of physical plant should be based upon the standards set forth in Section I, Sub-Section IV of this report.
- d. The physical plant should be so located, constructed, and designed as to provide the maximum balance of flexibility and present use.
 - (1) *Short-range flexibility*: Wherever possible, design should make provisions for program areas to serve a variety of functions, if any particular highly specialized function will not be handicapped by a design modification, general or specific. The extremes of this approach are the use of multi-purpose areas.
 - (2) *Long-range flexibility*: The physical plant design should possess such overall flexibility so as to be responsive to the advantages of additional knowledge accumulated with the passing of time.
 - (3) The specific location of program areas should be in such relationship to each other so as to maximize the advantages of the total program.

2. *Specific*

- a. The legal requirements for heating, lighting, and ventilation shall be the minimum standard.
 - (1) Production and distribution of heat facilities shall be adequate to maintain healthful and comfortable temperatures appropriate to climate conditions.

- (2) Auxiliary heat provisions shall be furnished for emergency situations.
 - (3) Minimum temperatures of 68° to 72° shall be maintained, depending on the type, age, condition, and activity of the residents.
 - (4) Adequate ventilation and lighting shall be provided in all areas with provisions for emergency lighting.
 - (5) Humidity shall be controlled to maximize the comfort and health of the residents.
 - (6) A minimum of 70 to 80 square feet of floor space shall be provided for each bed. Each room shall have direct outside ventilation. Window space in each room shall be at least 15 percent of floor space.
 - (7) All other construction details necessary to carry out the general provisions of item a. shall be furnished.
- b. Strict compliance with local and state fire regulations and periodic official inspections shall be observed. Also compliance with recommendations by inspecting authorities shall be the minimum standards for fire prevention and safety.
- (1) Buildings shall be of fire-proof construction and designed to maximize adequate and alternate safe exits.
 - (2) Exits, stairways, stair enclosures, fire escapes, dumb waiters, and laundry chutes shall be so arranged and designed as to prevent upward spread of smoke, fumes and flame.
 - (3) All other construction details necessary to carry out the general provisions of item b. shall be furnished.
- c. Strict compliance with local and state regulations for water supply, sewage disposal, plumbing, and screening shall be minimum standards for maintaining an optimum public health environment.
- (1) There shall be at least one lavatory for each eight to ten persons, one bathing unit (tub or shower) for each eight to ten persons, and one toilet for each eight to ten persons with separate toilets of suitable size for each sex when the individuals are over the age of eight years.
 - (2) There shall be individual racks or other drying space for wash cloths and towels.
 - (3) There shall be adequate hand-washing facilities in all bathrooms and toilet rooms.
 - (4) Adequate hand-washing facilities shall be provided in all kitchens, service rooms, toilet rooms, and treatment rooms.
 - (5) All other construction details necessary to carry out the general provisions of item c. shall be furnished.
- d. The buildings shall be so designed, constructed, and equipped as to maximize the benefits of efficient, ongoing housekeeping repair and

maintenance operations for the physical safety of residents and employees.

- (1) Hand rails shall be placed on all stairways.
 - (2) All dumb waiters, elevators, and other machinery with moving parts shall be provided with adequate guards.
 - (3) All other construction details necessary to carry out the general provisions of item d. shall be furnished.
- e. The site and buildings should meet the needs of the institution, community, and the state.
- (1) The physical plant should possess the essential elements and functional arrangements of a home.

- (a) *Sleeping*: These areas may consist of single, standard bedrooms, four-bed rooms, six-bed or small dormitories. For residents profiting most from personalized settings, four-bed rooms are both economical and socially developmental. (Two and three-bed room areas create social problems.) In general, it can be predicted that a design which includes a variety of these arrangements will prove the most satisfactory.

The size of the sleeping area, number of beds, and related comforts and conveniences should vary with the special needs of the particular grouping, and full consideration given to providing the combination of home-like living comfort, privacy, meaningful and helpful group associations, safety, health, etc., most appropriate for the special resident groupings.

Special nursing units can use at least 25 percent of their beds in single bed rooms, and the rest in larger rooms, but not larger than 12-bed units.

In geriatric units there are likely to be many residents who are physically disabled to some extent and, therefore, must spend a great deal of their time in or near their beds.

- (f) *Eating*: All residents should be provided with dining areas most appropriately designed for stimulating maximum self-development, social interaction, pleasure, and comfort. The space should be most conducive to highest sanitation and safety requirements. Where cafeteria style serving is appropriate, choice of food opportunities should be provided.

For the non-ambulatory residents served in the living units, planning of bed space should be oriented to a total living concept, space designed to provide as much of the essentials for all residents within the limits set forth by this category of residents.

Semi-ambulatory residents should have dining areas especially designed to accommodate the physical limitations of this group

and at the same time designed to maximize development of independent living, socialization, pleasure and comfort.

- (g) *Baths and toilets*: Space should be adequate and appropriately designed to provide for all basic health needs meeting the highest sanitation standards and at the same time afford a decent degree of privacy.
 - (h) *Storage*: Residents need, but seldom get, private storage space for personal belongings, in the form of lockers, dressers, bedside tables, bathroom shelf space, and the like. In addition, central storage facilities are needed for clothing and luggage which are not in constant use.
 - (i) *Living space*: By this is meant the type of space created in a home for family living. These areas are often called "day rooms," or "day space." It is space provided for rather sedentary entertainment such as would be suitable for evenings and other relatively non-active periods. It should be equipped with television, chairs, card tables, lamps, reading facilities, and the like.
 - (j) *Religious services space*: A chapel adequate in size and flexible in design so as to be adaptable to the needs of all religious denominations should be available. Space should also provide for the separate and special spiritual needs on an individual basis whether they are self sought, therapeutically prescribed, or part of the daily general rehabilitative program pattern of the institution.
- f. The physical plant should provide adequate and well-designed space for all special program functions. Adequate and appropriate space and equipment should be provided for all diagnostic, training, rehabilitation, and treatment services as required by the resident population served and the scope of outpatient services.

(1) *Medical*

Office

Medical and surgical services

Nursing services

Pediatric services

Orthopedic services

Psychiatric

Laboratories

Pharmacy

Occupational therapy

Physical therapy

Speech and Hearing Clinic

- Research
- Etc.
- (2) *Psychological*
 - Office
 - Testing
 - Interviewing, counseling, and treatment
 - Play therapy
 - Library
 - Conference room
 - Research
- (3) *Social Service*
 - Office
 - Interviewing (case work and interim service)
 - Group work
 - Conference room
- (4) *Educational*
 - Office
 - Special education classrooms
 - Physical education (facilities to be shared with recreational services)
 - Speech and Hearing Unit
 - Library
 - Music room
 - Research
- (5) *Training*
 - Office
 - Social competence classrooms
 - Vocational classrooms and special shop areas
 - Special space set aside in various industrial areas for counseling and counselors
 - Research
- (6) *Recreational*
 - Gymnasium } Can be combined when appropriate
 - Auditorium }
 - Athletic field
 - Wading pool
 - Swimming pool
 - Canteen
 - Outdoor playground area adequately equipped

(7) *Religious Services* (all denominations)

- g. The physical plant should provide appropriate and adequate space for management services.
- (1) Food storage, preparation, and distribution areas should be adequate in space, design, and in equipment so as to best provide wholesome, nutritious, attractive, and appetizing food to residents and employees, meeting the highest sanitation standards.
 - (a) There shall be adequate facilities for storing, preservation, and preparation of food, and attractive serving.
 - (b) Kitchen facilities shall comply strictly with all state and local regulations for dishwashing, screening, and food handling.
 - (c) Closed cupboards shall be provided for dishes.
 - (2) Power plant, laundry, maintenance shops, and all other central services should be adequately provided.
 - (3) Adequate office space and equipment should be provided for centralized business management functions, principally fiscal, including all related clerical operations.
- h. Adequate office space and equipment should be provided for administrative services including personnel service, public relations, volunteer services, etc. and the related clerical operations, record storage, etc.
- i. Adequate and attractive space should be provided for a receptionist station, public waiting room and visiting with residents.

B. Interpretation

1. Rehabilitation demands that the traditional residential facility concept be redirected to a community type of life as basic to design. Maximum contact with the outside world should be encouraged by the nature of the design. For example, many of the recreational and occupational activities of the residents can profitably take place in the outside community. Obviously, this is one of the many transitional bridges to a speedier return by the resident to normal community life. Many other advantages accrue from this approach, including a better overall understanding by the general public, thereby enhancing legislative efforts, community placements, volunteer services, exchange services, special training excursions, etc. This calls for abandonment of all the influences which have hitherto tended to isolate the institution from the community. It would be most desirable to locate near an institution of higher education for the advantages of research, staff recruitment, etc.
2. Primarily, design must be considered from a therapeutic, training and rehabilitative, and not merely from an administrative or maintenance, standpoint. Planners should adopt the concept of *space* as the essence of design, *space* in which personnel and residents can engage in various activities. These activities consist essentially of the same things which are done ordinarily in anybody's home or place of work. They include eat-

ing, sleeping, bathing, walking, sitting, playing, watching television, chatting with companions, engaging in hobbies, and working. Additional space required for the specialized therapy training, and rehabilitation services should be sufficiently supplemented and efficiently located so as to make possible the full program goals for which a residential facility can be geared.

3. Small units, wherever appropriate and expedient, should be incorporated and integrated within the total complex of design. Arrangement and sizes of the respective units should maximize opportunities for social development.
4. Design should also give consideration to the attraction of skilled personnel and provide facilities which maximize their potential skills. Plans for efficiently designed research, library, in-service training, and staff recreation space with provisions for flexible expansion should be given high priority.