AN ACTION PROGRAM FOR
THE MENTALLY RETARDED IN CALIFORNIA

PHASE I

A PROGRAM FOR THE DEPARTMENT OF
MENTAL HYGIENE

REPORT TO THE

SECRETARY OF THE HUMAN RELATIONS AGENCY

BY

THE TASK FORCE ON REVIEW OF

MENTAL RETARDATION SERVICES

JUNE 23, 1969

UNIVERSITY OF CALIFORNIA, IRVINE

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June 23, 1969

Mr. Spencer Williams, Secretary
Human Relations Agency
State Building No. 1, Room 427
Sacramento, California 95814

Dear Mr. Williams:

The Task Force for Review of Mental Retardation Services originally appointed by Dr. James Lowry, Director of the Department of Mental Hygiene, on May 10, 1968 and re-appointed by you on June 20, 1968 when its responsibilities were enlarged, herewith submits its report on Phase I of its studies. Phase I is concerned with the operations of the Department of Mental Hygiene in delivery of services to the mentally retarded.

You will recognize that Phase II and Phase III of the report, which deal with other State and community services for the retarded, will necessarily have some things to say about the interface between the Department of Mental Hygiene and other State and local agencies. Likewise this first report, although directed primarily to the operations of the Department of Mental Hygiene, has had to address itself in a few instances to the total constellation of services to the retarded in order to show those of this Department in context.

Respectfully submitted
for the Task Force,

Thos. L. Nelson, M.D.
Associate Dean
and
Chairman, Human Relations Agency Task Force on Mental Retardation Services

TLN/gst

PREFACE

This report presents the first part of a three phase review of mental retardation services provided or supported by California state government. The review is being conducted by a task force appointed by the Secretary of the California Human Relations Agency. The present state administration has taken the position that mental retardation programs, particularly community services,are to be strengthened. The purpose of this review is to identify ways in which state and local services to the mentally retarded might be made more effective and the product of better coordination.

The first phase has focused on operations of the Department of Mental Hygiene (DMH). However, the task force, composed of three members of the Department's Medical Advisory Committee, recognized that no organization such as DMH can effectively operate its programs without regard to services provided by others. It was inevitable, therefore, that in looking at the programs of DMH, the services of other agencies related to these programs needed to be considered. Since the subsequent phases of this study will include review of these related services in greater depth by an expanded task force, this report does not include any detailed commentary on these related services. Rather, it focuses primarily on those aspects of mental retardation services for which major responsibility currently rests within the Department of Mental Hygiene.

ACKNOWLEDGMENTS

In the course of this review of the Department of Mental Hygiene's system of services, the task force solicited the opinions and judgments of many people in and out of California state government. We are particularly grateful to the following persons who accompanied the task force members on their field surveys in November, 1968:

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(formerly with California Department of Public Health)

We express our appreciation to Robert Jaslow, M.D., Director, Division of Mental Retardation, Social and Rehabilitation Service, HEW, Washington, D.C., Wesley White, Ed.D., Chief, Division of Mental Retardation, Department of Institutions, Denver, Colorado, and George Tarjan, M.D., Acting Medical Director of the Los Angeles Neuropsychiatric Institute and member of the President's Committee on Mental Retardation, for their valuable counsel.

We are also appreciative of the cooperation and assistance given us by personnel at the various state hospitals and at Department Headquarters and field offices.

While the task force sought and received counsel from all these sources, it should be emphasized that this report represents the views of the task force members and does not necessarily represent the views of those with whom the task force consulted or interviewed.

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SUMMARY OF REPORT

Subject: Human Relations Agency Task Force review of Department of Mental Hygiene services to the mentally retarded.

Objectives: To assess present system of services and recommend needed organizational and program adjustments as well as guidelines for further program development.

Method of Study: Task force held meetings with state hospital management staff, with representatives of consumer groups, and with committee on mental retardation, Conference of Local Mental Health Directors. Task force reviewed various DMH planning documents and reports of state hospital surveys conducted by other organizations and individuals. Accompanied by nationally recognized authorities on mental retardation, task force surveyed thirteen state hospitals. Task force also interviewed various administrative and program personnel at DMH Headquarters. Interval of study: July 1, 1968 to March 31, 1969.

Findings: Despite some gains, DMH services to the mentally retarded have not kept pace with newer, well recognized concepts of program development for the mentally retarded. There is inadequate planning with other state and local agencies and organizations toward development of coordinated programs. Treatment and developmental needs of hospital residents are not being adequately met. With some noteworthy exceptions, control and custody are still the predominant features of most DMH programs. Present administrative structure and personnel utilization and training do not stimulate and promote adequate program development.

Recommendations:

Quality of Life (page 19)

For Action by Secretary, Human Relations Agency

1. A statewide master plan should be developed and updated annually for implementing the proposals developed by the California Study Commission.

2. A single point of entry should be established in each community to help parents define needs, reach appropriate resources, and periodically re-evaluate service requirements of their children.

3. Residential services should be regionalized so as to provide services at all levels from community to state care and as close as possible to the individual's home consistent with quality care.

4. Experimental and innovative models of community residential care should be encouraged through expansion of budgets for placement programs from state hospitals.

For Action by the Director of Mental Hygiene

5. The Departments of Mental Hygiene and Social Welfare should jointly (a) determine the nature and extent of the placement, funding, and staff resources required to effect movement of residents out of the state hospitals who no longer require state operated residential services, (b) mobilize such resources, and (c) expedite placement of the residents.

6. For those persons who require state residential care, services should be organized consistent with broad program goals and sufficient budgetary support to achieve the maximum developmental potential of each resident.

7. DMH residential services for the mentally retarded at any one facility should include no more than 500 residents in a Medical Program for the Multiply Handicapped (Type I), no more than 150 in a Developmental Program (Type II), and no more than 150 in a Rehabilitation Program (Type III).* The design of each dormitory, ward or cottage should permit living and program groupings not to exceed eight persons in Type I programs, eight persons in Type II programs, and four persons in Type III programs. Facilities for Type II and Type III programs should permit each individual a place to call his own and which approximates a home environment. Buildings should be sequentially remodeled or closed so as to effect reduction to these standards within the next ten years.

8. A type and level of staffing should be developed for mental retardation programs that would permit individual and small group programming in keeping with recommendation No. 7, above. The recommendations on page 51 provide a method for developing such staffing.

9. The director of each MR service in a state institution should develop a program for individual residents or groups of residents so that all care and treatment personnel may know at any moment in a resident's institutional stay (a) what stage of development he is in, (b) where he is going, and (c)

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*See page 39 for description of these three programs.

what is to be anticipated in his eventual development. The program should always be in a state of flux with no ceiling placed on individual potential.

10. There should be greater exchange of resources between state hospital and community; the hospitals should purchase high quality community services where available and state hospitals should develop easily accomplished procedures for short term admissions from the community.

11. Hospital projects that have proven their worth experimentally, whether supported by federal funds or state research funds, should be continued as part of the ongoing hospital operations budget. Efforts should be made to translate the results of such projects into programs throughout the hospital system wherever appropriate and with sufficient funding.

12. Educational services in DMH facilities should be provided in accordance with standards of the California Department of Education for Special Education programs in public schools.

Department Organization and Management (page 34)

For Action by Secretary, Human Relations Agency

13. Active support should be given toward obtaining substantial increases in salaries for the Director of Mental Hygiene and subordinate administrative and program personnel.

For Action by the Director of Mental Hygiene

14. DMH Headquarters should be reorganized, placing the Director and the two Chief Deputy Directors within the Office of Director.

15. The functions of the Division of Hospitals and Division of Local Programs should be consolidated and redistributed between a Division of Mental Retardation Services and a Division of Mental Health Services.

16. Services to the mentally retarded in state institutions should be headed by a Program Director responsible to the Deputy Director, Mental Retardation Services. There should be three broad program classifications: (a) Medical, (b) Developmental, and (c) Rehabilitation, each headed by a Program Chief responsible to the Program Director. Qualifications for Program Chief should be dependent on the program classification.

17. Development of MR programs in facilities on the grounds of MI hospitals is supported as a temporary expediency and only under certain conditions and guidelines: (a) written plan approved by Deputy Director, MR Services, (b) implementation of plan before admission of residents, (c) transfers by small increments, starting with Rehabilitation Programs, and (d) linkage of MR/MI facility to a parent MR facility.

18. DeWitt State Hospital should be phased out as a facility for the mentally retarded.

19. Parental consent for placement out of state institutions into community facilities should be retained as a normal requirement, with an appeal procedure developed to sources outside of the facility for adjudication of differences between staff and the responsible relative. A consumer representative (not a relative) should participate in the adjudication process.

Personnel Utilization and Development (page 51)

20. Basic care personnel in Medical Programs for the Multiply Handicapped (Type I) should be licensed vocational nurses (LVN) and registered nurses (RN).

21. Basic care personnel in Developmental Programs (Type II) should be child development aides and child development specialists.

22. Basic care personnel in Rehabilitation Programs (Type III) should be psychiatric technicians.

23. Promotion, retention, and merit salary increases for physicians in MR programs should be based primarily on a critical annual review of performance as demonstrated in a clinical setting for the mentally retarded, irrespective of specialty background of the physicians.

24. Basic residency programs for physicians should be continued for psychiatric programs and extended to pediatrics, emphasizing mental retardation and related handicapping conditions.

25. More opportunity should be given all basic care personnel for upward mobility into various management and professional classes in order to fill manpower needs.

26. Basic training for the various basic care personnel should occur in junior colleges with DMH providing stipends and field practice settings.

INTRODUCTION

Background

The California Department of Mental Hygiene is responsible for delivering and supporting a broad range of services to the mentally ill (MI) and mentally retarded (MR) throughout the state.

Traditionally, the MI workload has been substantially greater than the MR workload. For example, on June 30, 1958, the MI resident population in the state hospitals was 36,979 (79%) and the MR resident population was 9,790 (21%). During the ensuing years, the MI population has been significantly reduced while the MR population has increased. On June 30, 1968, there were 18,831 MI patients (58%) in residence and 13,355 MR individuals (42%) in residence. Thus, the MR program now represents a much larger portion of DMH residential services than it has in the past.

How well is the Department performing its mission with respect to the mentally retarded? What problems exist with its present system of services? What are the strengths of the system? How might deficiencies be corrected and strengths deployed throughout the system? What guidelines need to be developed for the future? To seek answers to these and related questions, a task force was constituted by the Director of Mental Hygiene in the spring of 1968, composed of three members of the Department's Medical Advisory Committee: Drs. Thos. L. Nelson, Richard Koch, and Irving Philips.

When the proposed project was reviewed with the Secretary of the Human Relations Agency, he requested that the task force include several other

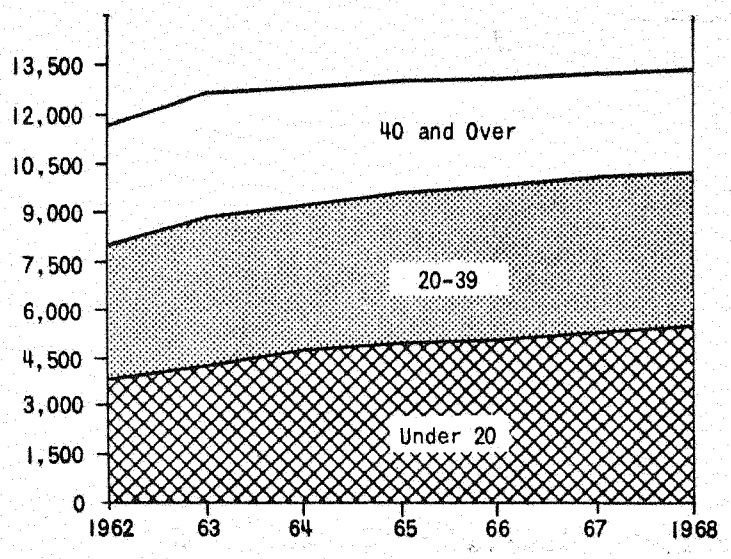
matters in its study which were not within the jurisdiction of DMH. It was agreed, therefore, that the task force would be responsible to the Agency Secretary and it would undertake to review the broad range of services to the mentally retarded that are provided or supported by various departments within the Agency. Staff services to the task force would be provided by the DMH Program Review Unit.

The task force in its early deliberations recognized that the review of other than DMH services would require an expansion of its membership and it would need to include persons with varied backgrounds. The Agency Secretary agreed that for the subsequent portions of the study, this would be done. This report, then, concerns itself only with the first phase of the study - a review of the Department of Mental Hygiene's system of services.

Trends Toward More Severely Retarded, Younger, and Multiply Handicapped

In 1961-62, about 66% of admissions to California's state hospitals for the retarded had I.Q.'s under 40. In 1967-68, almost 70% had I.Q.'s under 40, according to DMH Bureau of Biostatistics.

This trend toward an increasing proportion of admissions of severely and profoundly retarded, along with active programs of placement (usually of the relatively brighter and not multiply physically handicapped group) has resulted in the state hospitals for the retarded having an increasing proportion of severely and profoundly retarded among their residents, as shown in the following graph.



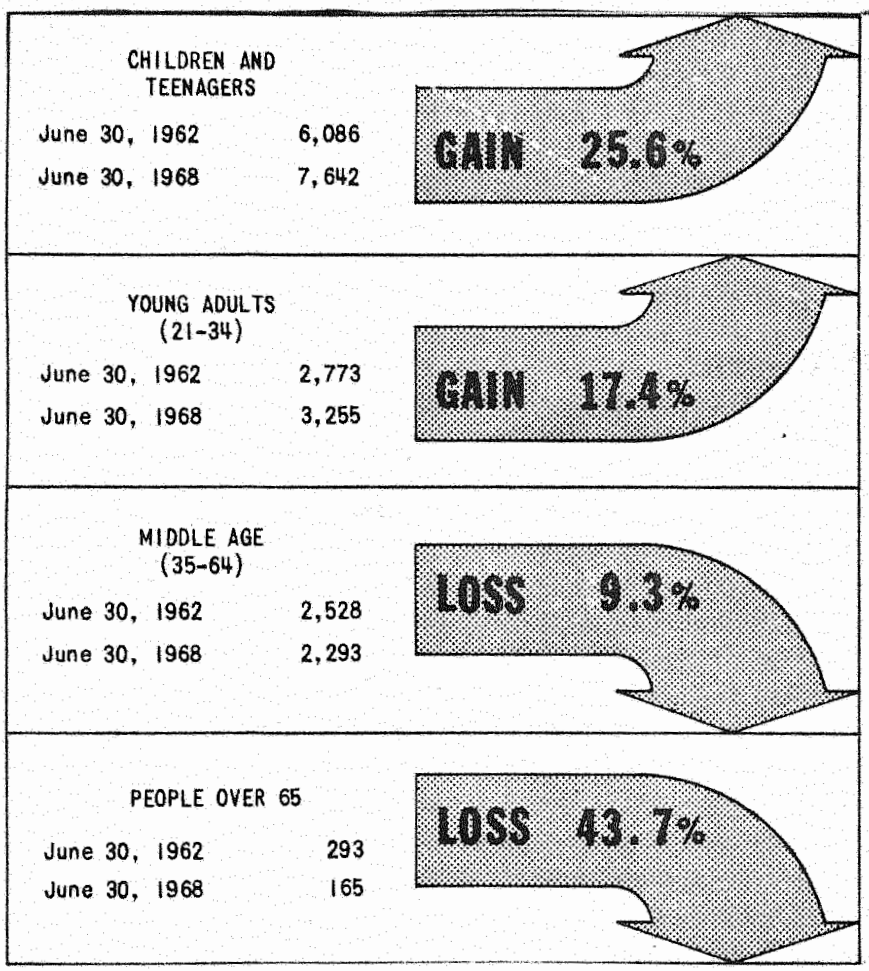
Inpatient Population by I.Q. Groups[1]

For the inpatient population the growth from fiscal year 1961-62 to fiscal year 1967-68 in the group having IQs under 20 amounted to 40 percent. It was 15 percent for those having IQs from 20 through 39. A decrease of 14 percent occurred in the number of patients having IQs 40 and higher. This decrease was due to the increase in community placement of the less severely retarded.

Another change which accompanies the trend toward more severe degrees of retardation is an increasing proportion of residents being in the younger age groups as shown on the following page.

[1]DMH, Bureau of Biostatistics, "Statistical Bulletin", Volume 2, No. 8, December 23, 1968, p. 13.

INPATIENT POPULATION HAS INCREASED IN THE YOUNGER AGE GROUPS [1]



The younger segments in the inpatient population have continued to increase whereas the older segments have continued to decrease. Among the factors contributing to these trends are an increase in young admission entries, a decrease in old admission entries, and an increase in community placement of the older patients.

Two major categories of admissions can be identified. The larger group is comprised of infants and young children with severe degrees of retardation caused by an organic defect. This type of child is generally recognized early in life as being retarded. Usually, he has associated defects giving him multiple handicaps, such as cerebral palsy, convulsive disorder, sensory defects,

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[1] Ibid. p. 14.

physical and chemical anomalies, and genetic aberrations. An unusually high frequency of infections and nutritional problems is also seen in this group. The second type of admission, which is seen with considerably less frequency than the first, but which makes a distinct group, is composed of adolescents and young adults with mild to moderate degrees of retardation which frequently is not clearly determined to be on an organic basis. Rather, the retardation more frequently appears to be caused by familial, environmental, and social factors. Behavioral rather than physical disorders tend to represent the major handicap in this group.

End of Year Workload

As of June 30, 1968, the MR resident and leave census was as follows:*

State Hospital	Resident	On Leave
Fairview	2518	860
Pacific	2726	1368
Porterville	2427	758
Sonoma	3322	929
Agnews	467	39
Camarillo	482	44
DeWitt	917	353
Patton	496	116
Totals	13,355	4,467

Fairview, Pacific, Porterville, and Sonoma are exclusively hospitals for the mentally retarded. A combination of overcrowding and continuous pressures for admission resulted in the decision many years ago to secure relief via

*Provided by Department of Mental Hygiene, Bureau of Biostatistics

utilization of DeWitt and Patton for the care and treatment of MR. The method selected was to transfer patients from the MR hospitals, thus freeing space in the MR hospitals for direct admissions from the community. In more recent years, Agnews and Camarillo have been utilized similarly.*

A Look at the Future

It would appear that some type of state residential services for the retarded will continue to be required for many years. Even if some miracle could produce the necessary facilities in communities and outside of state auspices to meet all the hospital and residential needs for those applying to state facilities, the latter would still have to continue operations for many years in order to care for persons presently in residence. However, we expect the trends toward more severe degrees of retardation, toward the younger age groups, and toward multiply handicapping conditions to continue.

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*Also, a small unit was recently opened at Napa for transferees from Sonoma. Fifty-two patients were in residence at the time of the Napa visit by the task force.

METHOD OF STUDY

The task before the group was to look at DMH operations as broadly as possible within the limitations of available time (July 1, 1968 to March 31, 1969) and recommend changes in the system of services that seemed indicated. Each of the three task force members has been familiar with Department of Mental Hygiene operations for many years.

Meetings with State Hospital Representatives

Following review of various documents,* the task force met with state hospital medical directors or their representatives in July in order to discuss procedures. Two meetings were held, one in San Francisco with representatives of northern hospitals, and one in Los Angeles with representatives of hospitals in the southern part of the State. Subsequently, the hospital medical directors were asked to respond to questions pertaining to existing and potential programs. The responses were utilized by the task force and consultants as resource documents in the hospital surveys.

Survey of State Hospitals

For purposes of this phase, the 13 state hospitals to be surveyed (all but Atascadero) were grouped into three regions, with a task force member responsible for each region.

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*Included among the documents were the state hospital survey reports of the California Medical Association and those of the American Association on Mental Deficiency, and the report to the governor and legislature entitled "The Undeveloped Resource - A Plan for the Mentally Retarded in California", Study Commission on Mental Retardation, Sacramento, California, January 1965.

Assisting each task force member in the surveys were three consultants in mental retardation drawn from various parts of the country. They were supplied with various resource materials prior to their arrival for the surveys. The composition of each team was as follows:

Northern Team (Sonoma, DeWitt, Napa)*

Irving Philips, M.D. - Task Force Member

Martha Adams, R.N. - School of Nursing, UC Medical Center (San Francisco)

Gunnar Dybwad, J.D. - Graduate School of Social Welfare, Brandeis University

Ivy Mooring, Ph.D. - Los Angeles County Mental Retardation Services Board

Central Team (Porterville, Modesto, Stockton, Agnews)

Richard Koch, M.D. - Task Force Member

Elizabeth Boggs, Ph.D. - National Association for Retarded Children

William Hirsch, Ed.D. - Lowman School for Handicapped Children (Los Angeles)

Patricia McNelly, R.N. - Central Wisconsin Colony and Training School

Southern Team (Fairview, Pacific, Patton, Camarillo, Metropolitan)

Thos. L. Nelson, M.D. - Task Force Member

Kathryn Barnard, R.N. - School of Nursing, University of Washington (Seattle)

Herbert Goldstein, Ph.D. - Department of Education, Yeshiva University (New York)

Belle Dale Poole, M.D. - Private Consultant in Maternal and Child Health (New Hampshire)

Because of scheduling difficulties, the three teams were not able to conduct their surveys simultaneously. The central team conducted its surveys during

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*Mendocino State Hospital was surveyed by Drs. Philips and Koch in July, 1968.

the week of November 11 - 15, 1968. Drs. Philips and Nelson participated in the summing up session on November 16. The northern and southern teams conducted their surveys during the week of November 18 - 22. Dr. Koch participated in their jointly held summing up session on November 23. The Project Manager spent a portion of each week with each team and attended both summing up sessions. Also, Dr. Nelson visited DeWitt and Dr. Koch visited Sonoma following this phase. Thus, considerable overlap and continuity was achieved.

Accompanying each team during its surveys was either the Assistant Deputy Director, Mental Retardation Services or the Assistant Deputy Director, Mental Health Services, both from the Division of Hospitals at DMH Headquarters. Community Program Analysts from the Regional Offices of the Division of Local Programs acted as general team guides and resource persons.

Two-day visits were made to Sonoma and to Porterville. One-day visits were made to the other hospitals. The general pattern was for the entire team to first meet with the medical director and his key staff, following which team members visited areas of the hospital in accordance with their specialties. A summary session was held at the end of the visit with the medical director or his designate. In some instances team members also had the opportunity of visiting adjacent community facilities, such as a foster home or a developmental center.

Meeting with Citizen Groups

During December, the task force met jointly with the executive board of the California Council for Retarded Children and representatives of the various

hospital parent groups for purposes of reviewing the project and soliciting viewpoints on DMH services to the mentally retarded.

Meeting with Short-Doyle Directors

Following presentation of the project's objectives at a general meeting earlier in the fall, the task force met in February with an ad hoc committee of the Conference of Local Mental Health Directors for the purpose of exploring the position of that organization with respect to the role of local Short-Doyle programs in providing services to the mentally retarded.*

Interviews with Headquarters Personnel

The task force conducted private interviews in February with various staff members at DMH Headquarters for purpose of gaining a better understanding of their responsibilities, objectives and viewpoints with respect to services to MR. They included:

Deputy Director, Division of Hospitals

Assistant Deputy Director, Mental Retardation Services

Assistant Deputy Director, Mental Health Services

Chief, Bureau of Medicine and Surgery

Chief, Bureau of Nursing

Chief, Bureau of Social Services

Chief, Bureau of Rehabilitation and Education

Chief Deputy Director, Office of Administrative Management

Deputy Director, Division of Local Programs

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*Short-Doyle services, along with those of other community agencies, will be discussed in detail in Phase II of the study.

Chief, Bureau of Training

Chief, Bureau of Research

Chief, Personnel Services Unit

Chief, Bureau of Facilities Planning

Chief, Program Planning Unit (and staff)

Following these interviews, the task force met with the Director of Mental Hygiene.

QUALITY OF LIFE

RECOMMENDATIONS

For Action by Secretary, Human Relations Agency

1. The Secretary of the Human Relations Agency should develop a master plan for achieving the goals set forth in the document referred to earlier in this report, "The Undeveloped Resource, A Plan for the Mentally Retarded in California." This document expressed a philosophical approach which dictates that the general goals of programs for the mentally retarded are to allow for maximum growth, development, and fulfillment for each individual who is mentally handicapped. The master plan should be updated annually in keeping with changing needs and newer trends of care.

2. A single point of entry should be established in each community, whether it be a Regional Center contract agency, a local public health department, or a Short-Doyle program, to help parents define the specific needs of their child and reach the appropriate service resource. The entry point should maintain a liaison in perpetuity with the individual, the family, and the various services available to them.

3. An effort should be made immediately to implement regionalization of care so as to provide residential services for mentally retarded individuals at all levels from community to state care and as close as possible to the individual's home consistent with quality care.

4. Experimental and innovative models of community residential care should be encouraged through expansion of present programs for placements from state hospitals into family homes, hostels, cooperative living projects, nurseries, and schools.

For Action by the Director of Mental Hygiene

5. The Departments of Mental Hygiene and Social Welfare should jointly (a) determine the nature and extent of the placement, funding, and staff resources required to effect movement of residents out of the state hospitals who no longer require state operated residential services, (b) mobilize such resources, and (c) expedite placement of the residents.

6. For those persons who require state residential care, services should be organized consistent with broad program goals and sufficient budgetary support to achieve the maximum developmental potential of each resident.

7. DMH residential services for the mentally retarded at any one facility should include no more than 500 residents in a Medical Program for the Multiply Handicapped (Type I), no more than 150 in a Developmental Program (Type II), and no more than 150 in a Rehabilitation Program (Type III).* The design of each dormitory, ward or cottage should permit living and program groupings not to exceed eight persons in Type I

*See page 39 for description of these three programs.

programs, eight persons in Type II programs, and four persons in Type III programs. Facilities for Type II and Type III programs should permit each individual a place to call his own and which approximates a home environment. Buildings should be sequentially remodeled or closed so as to effect reduction to these standards within the next ten years.

8. A type and level of staffing should be developed for mental retardation programs that would permit individual and small group programming in keeping with recommendation No. 7 above. The recommendations on page 51 provide a method for developing such staffing.

9. The director of each MR service in a state institution should develop a program for individual residents or groups of residents so that all care and treatment personnel may know at any moment in a resident's institutional stay (a) what stage of development he is in, (b) where he is going, and (c) what is to be anticipated in his eventual development. The program should always be in a state of flux with no ceiling placed on individual potential.

10. Greater exchange of resources between state hospital and community should be encouraged. DMH facilities should purchase high quality services for their MR residents when such services are available in the community. The state hospitals should develop easily accomplished procedures for short term admissions for such purposes as camping programs, respite and crisis care, and such.

11. Hospital projects that have proven their worth experimentally, whether supported by federal funds or state research funds should be continued as part of the ongoing hospital operations budget. Efforts should be made to translate the results of such projects into programs throughout the hospital system wherever appropriate and with sufficient funding.

12. Educational services in DMH facilities should be provided in accordance with standards of the California Department of Education for Special Education programs in public schools.

DISCUSSION

The conditions observed in state hospitals by the task force and its consultants have been present for many years in spite of increases in annual budgets for mental retardation services. Successive administrations, political and professional, have not resolved the major problems related to services to the mentally retarded and their families. The present system of delivery of services does not adequately serve the mentally retarded person or his family and is economically wasteful. The many studies that have been made[1] have emphasized deficiencies in patient care and the quality of life in the institutions. Leadership and planning for the mentally retarded have been insufficient to fully implement recommendations that have been made. Those that have been implemented dealt with such urgent necessities as preventing inhumane care and, although desirable, did not change the general situation or direction. Lack of general public interest and understanding has permitted the perpetuation of the concept of control and custody rather than the development, growth, and sense of well-being of the individual hospital resident.

This report points out deficiencies in the general system of state hospital care for the mentally retarded and their families. The purpose of the report

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[1] E.g., those by the California Medical Association and the American Association on Mental Deficiency. Also, see Babow, Irving, PhD., and Alonza C. Johnson, M.D., D. Sc., "Staff Attitudes in a Mental Hospital Which Established a Mental Retardation Unit", Condensed in California Mental Health Research Digest, Winter 1969, published by DMH, Bureau of Research.

is to recommend an action plan for correction of these deficiencies. The task force noted again and again and would like to commend the efforts performed by many of the treatment staff in each hospital in the performance of their duties, often under trying and difficult circumstances. Nevertheless, they must operate under a system of delivery of services which tends to emphasize control and custody rather than rehabilitation and development of potential of each individual.

Entry of a mentally retarded person into a state hospital presents many difficulties for him and his family. As the Sonoma State Hospital Medical Director stated to a senate subcommittee, "the hospital is oversized, overcrowded, underbudgeted and overcontrolled". The task force is in complete agreement. We believe that the four hospitals for the mentally retarded are much too large and too crowded to carry out adequate programs toward worthwhile goals for individuals or small groupings of residents. There were exceptions, and at each hospital isolated projects have been developed that appeared to be well-designed and were producing good results. However, most projects which were innovative and which came closest to serving patient needs were financed at the expense of other programs or were financed through federal or state grants for special projects. These projects frequently were initiated, directed, and reflected the special enthusiasm of someone other than a physician. This was true even though, on official organization charts, the ward physician had the responsibility for program direction. These projects were usually on a tenuous basis of support. If supported by grants, assurance was not given that the project could continue after such special financing

ceased. Even where these projects were obviously successful and recognized as such throughout the hospital, there was lack of planning (and therefore apparent lack of interest) on the part of hospital and departmental administrators toward integrating them into ongoing operations via budgetary requests. The Director of Mental Hygiene reported that because of limited funds to sustain all programs, a program for a limited number might not be continued despite its proven worth because it would have to compete with programs designed to serve larger numbers.

In 1968, the state standard for the rated bed capacity of state hospitals was improved from 55 square feet to 70 square feet. Implementation of this higher standard in the MR/MI hospitals has provided a more comfortable living situation for residents. Overcrowding continues to exist at each of the four primary hospitals for the mentally retarded.

Although overcrowding at these four hospitals can be alleviated by transfer of residents to other hospitals, the essential quality of program will remain the same, as funds still are not sufficient to provide a program for each resident to develop to his fullest potential. Also, the transfer of persons to other large state institutions without substantive program changes will perpetuate the concept of custody and control rather than active therapy directed to the attainment of maximum potential for each resident.

The next section of this report (page 39) describes a three program classification system that should be developed with respect to DMH residential services to the mentally retarded. It has been stated, and aptly so, that

"it is impossible to design a successful environment within the framework of a large institution."[1] It would be our judgment that at any given facility, a Medical Program for the Multiply Handicapped should be limited to 500 residents; a Developmental Program limited to 150 residents; and a Rehabilitation Program limited to 150 residents.

Large, outdated buildings add to the problems of developing adequate programs. They are much too large to permit work with individuals or small groups so that in general one saw, much too frequently, groups of from fifty to over a hundred persons herded together and milling about in a large ward, congregated in front of a television set, or congregated in a day room with little or nothing to do. There are few, if any, goal directed plans operating at most times. The large wards provide little opportunity for privacy or individuality. In some wards, the residents never get out of bed and are merely "changed" and fed, even though many ward personnel informed us that some patients, when up, respond more appropriately and learn to feed themselves. Many of these buildings are in poor repair and are in deteriorating condition, although at most of the hospitals, some refurbishing is in evidence. The task force believes that the design of living units should permit living and program groupings not to exceed eight persons in Type I programs, eight persons in Type II programs, and four persons in Type III programs. Facilities for Type II and Type III programs should permit each individual a place to call his own and which approximates a home environment. "The standards of the physical facilities....should be the same as those regularly applied in society

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[1]Sokoloff, H. David, "Choosing the Future", The Challenger, CCRC, March 1968.

to the same kind of facilities for ordinary citizens." [1] Although the task force would like to see these achieved immediately, it recognizes that practically they can only be achieved in sequential steps over several years.

The survey teams saw chronic understaffing in almost every ward visited. It is recognized that compliance with the SCOPE standards adopted in 1968, based on the Staffing Standards for Public Hospitals study will improve the level of care. For example, in the 1968-69 budget, the administration added 357 psychiatric technician positions serving the mentally retarded. An additional 193 positions have been requested in the Governor's Budget for 1969-70. However, full compliance will not fully achieve the objectives outlined in this report. For instance, we were informed by the Director that the Department was at 78% of standard at hospitals for MR in September, 1968. Adding more personnel to achieve 100% of staffing standards without also changing the philosophy of care and the administrative structure would achieve little. Increase in staff alone would allow for better humanitarian care, but would not achieve any of the needed program and administrative changes envisaged by this report. The American Psychiatric Association has noted that "every mental health worker must have three unshakable beliefs: that the mental hospital is not the natural habitat of man; that there is no such thing as a hopelessly ill mental patient; and that every employee and every volunteer who works in the hospital is important to patient treatment". These concepts are also applicable to the mentally retarded but are not yet accepted completely in the state hospital system. The numbers of rehabilitation personnel are below standards

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[1] Nirje, Bengt, "The Normalization Principle and its Human Management Implications" in Changing Patterns in Residential Services for the Mentally Retarded. Washington, D.C., President's Committee on Mental Retardation, 1969, p. 185.

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set by the American Association on Mental Deficiency; for example, there were only 24 rehabilitation personnel at Sonoma State Hospital. At the time of the task force surveys, (November, 1968) there was a shortage of maintenance staff, a shortage of laundry personnel, a shortage of food service personnel, and a shortage of kitchen staff. Personal care staff was too often involved in janitorial, maintenance, and food service duties that subtracted from the amount of time available to work directly with residents. The task force is pleased that the 1969-70 Governor's Budget requested additional positions in the area of maintenance, and additional relief to treatment personnel from janitorial and food service duties.

This report emphasizes the need for the development of programs for each individual during his stay in any state residential facility. No program can be successful without sufficient personnel or funds to achieve desired results. The training of ward personnel generally is inadequate for the job of developing programs for individuals or groups, yet ward personnel frequently assume this task by default of leadership and direction by professional staff. When a treatment program exists at all, it is often only habit training. Most nurses and technicians, when asked what program is available for a given individual could not define any program or goal for him other than attention to his basic needs. It is evident that specific goal-directed plans are not formulated for each individual and conveyed to ward staff. Sometimes there was a marked discrepancy between what the hos-

pital medical director thought was happening on a ward and what treatment personnel on the ward thought they were doing. One medical director remarked that 90 to 95% of psychiatric technician time was devoted to patient training programs on the wards. Direct observation by survey team members failed to disclose anything remotely related to such a level of programming. When one inquired of the psychiatric technicians on the wards of this facility, they shrugged their shoulders and seemed to be quite unaware that anything of this nature was being accomplished.

There are indications that the hospitals are underbudgeted in almost every category, from programs for patient care to maintenance of structure. Lack of adequate leadership and lack of sufficient funds combine to make it difficult to initiate needed programs. It was observed that ward care of patients often consisted of herding them into large groups for baths, toileting, cleanup, and being put to bed. Night visits provided evidence of too few personnel. Only an impoverished life and a minimal opportunity for stimulation was possible because of obsolete facilities, shortage of personnel, and tradition of control and custody.

Little is being accomplished to meet the objectives that one would expect of a residential facility concerned with the needs of a growing child. Although most of the residents are kept clean and are essentially well fed, opportunities for personality and social development are extremely limited. Some impressive programs exist such as the behavior shaping program at Patton, the programs for the blind and deaf and orthopedically handicapped at Sonoma, and the extensive research program at Pacific State Hospital; but these are isolated instances, and even at these hospitals, very few residents are involved

in these programs. At Fairview, vital elective surgery for orthopedic care and indicated surgery for strabismus were not being performed, reportedly because of insufficiency of consultation funds for paying outside physicians. If the patients requiring such treatment were residing in the community, many would have such treatment paid for by public programs such as Medi-Cal. Either regulations should be changed so as to permit outside physicians to bill Medi-Cal for their services, or sufficient consultation funds should be appropriated to meet the needs for elective surgery for all residents.

Many children who would benefit from schooling are not attending school at all; others are inappropriately attending less than half a day. They are penalized by being in the hospital; for many, if they were in the community they would be enrolled in Developmental Center or other school programs. According to DMH figures obtained from the Bureau of Rehabilitation and Education, there were 105 persons on the teaching staffs in the state hospitals at the beginning of the 1968-69 fiscal year serving 1,771 MR patients. An additional 143 teachers, including supervisors, and 119 teacher assistants would be required in order to meet teacher ratios established for public school programs. This would permit educational services to 2,375 multi-handicapped children who are not now enrolled in hospital education programs. These additional positions should be requested in the 1970-71 Governor's Budget. The task force believes that these positions are urgently needed.

In some places, it was noted that even though a program for learning new skills is developed at the hospital school, what is learned in the school often is

undone on the ward. The school teaches the child how to explore his environment, to do more for himself; when he returns to the ward, the staff, because of the large number of patients, tradition, and lack of program planning, frequently emphasizes restriction of individual activity, thus undoing what has been learned in school. This major deficiency was found repeatedly and has been noted previously.[1] Since the state hospital population will be more severely handicapped in the future, it seems logical that fewer residents will be of sufficient potential to meet the qualifications for the equivalent of trainable and educable programs in public schools. Therefore, exploration with local public school resources should be initiated so that those residents who do qualify can receive the full range of services to which they are entitled.

The hospital medical directors informed us that many patients could be discharged if 1) community programs were available, 2) alternate services and facilities could be utilized and developed, 3) parents would consent to placement other than in a hospital, and 4) funds were available to the Department of Social Welfare to pay for care.

While there has been an increasing number of persons released each year from the hospitals,* there is lack of comprehensive evaluation of release programs, so little is actually known as to what gains, if any, are made; which programs produce best results; and which experiences in the hospital contribute most to progress in the community.

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[1]Thormahlen, Paul W., A Study of On-the-Ward Training of Trainable Mentally Retarded Children in a State Institution, Research Monograph #4, DMH, 1965

*Patients on leave of absence have increased from 2,500 in 1964 to 4,800 in 1969.

Along with evaluation of ongoing placement programs, there needs to be encouragement of experimental and innovative models of community residential care through expansion of present budgets for placements from state hospitals into family type homes, hostels, cooperative living projects, nurseries, schools, etc.

In summary, not enough is being done for the development and expansion of constructive programs or pursuance of program goals. Not enough has been accomplished in furthering the growth and developmental potential of individuals. Not enough is done to maintain contact with families so that the child may benefit in his continued development. Not enough is done by the hospital staff toward rehabilitation and physical and occupational therapy services for residents on the wards. Few vocational rehabilitation programs exist that might encourage long-range plans for individual residents who might fare better in the community. Large populations and overcrowding in the four primary hospitals and insufficient numbers of adequately trained personnel in all the facilities result in custody and control, with insufficient regard for the individual needs of the developing child and adult and for programs that would lead to the rehabilitation and resulting increased well-being and dignity of the individual.

According to the DMH Bureau of Budget Planning, in 1967-68 the DMH budget for mental retardation services in state hospitals was $64,905,672 of which $7,736,490 -- or 11.9%, was returned to the State as revenue from various sources, including federal program reimbursements, leaving a net cost to the State of $57,169,182. In 1968-69, it has been estimated that 31.7%, or

$23,352,234 of the $73,623,775 budget will be returned as revenue, leaving a net cost to the State of $50,271,541. Thus, fewer State tax dollars will have been expended for DMH services to the mentally retarded. This fact should be considered in determining the cost of implementing recommendations in this report.

DEPARTMENT ORGANIZATION AND MANAGEMENT

RECOMMENDATIONS

For Action by the Secretary, Human Relations Agency

13. Active support should be given to legislation that would permit substantial increases in the salaries of the Director of Mental Hygiene and subordinate management and program personnel.

For Action by the Director of Mental Hygiene

14. DMH Headquarters should be reorganized, placing the Director and the two Chief Deputy Directors within the Office of Director.

15. The functions of the Division of Hospitals and Division of Local Programs should be consolidated and redistributed between a Division of Mental Retardation Services and a Division of Mental Health Services.

16. Services to the mentally retarded in state institutions should be headed by a Program Director responsible to the Deputy Director, Mental Retardation Services. There should be three broad program classifications: (a) Medical, (b) Developmental, and (c) Rehabilitation, each headed by a Program Chief responsible to the Program Director. Qualifications for Program Chief should be dependent on the program classification.

17. Development of MR programs within facilities on the grounds of MI hospitals is supported as a temporary expediency and only under certain conditions and guidelines: (a) written plan approved by Deputy Director, MR Services,

(b) implementation of plan before admission of residents, (c) transfers by small increments, starting with Rehabilitation Programs, and (d) linkage of MR/MI facility to a parent MR facility.

18. DeWitt State Hospital should be phased out as a facility for the mentally retarded in accordance with procedures described on page 46.

19. Parental consent for placement out of state institutions should be retained as a normal requirement, with an appeal procedure developed to sources outside of the facility for adjudication of differences between staff and the responsible relative. A consumer representative (not a relative) should participate in the adjudication process.

DISCUSSION

As part of its responsibilities, the task force was requested to review the system of organization and management within the Department of Mental Hygiene both at Headquarters and at the state hospitals. The single most important observation made by the task force regarding the management of mental retardation services was the lack of overall planning, direction and goals. This management deficiency permeated the entire system from the Headquarters level through the medical directors of the various state hospitals, the ward physicians, down to the psychiatric technician level. An important reason was the lack of clear differentiation between mental illness and mental retardation services, especially at Headquarters; rather, the two are treated as one, which of course they are not. In our opinion,

(b) implementation of plan before admission of residents, (c) transfers by small increments, starting with Rehabilitation Programs, and (d) linkage of MR/MI facility to a parent MR facility.

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mental retardation programming in DMH will never develop in a viable vigorous manner under the present organizational structure which is dominated by administrators and program specialists who have their major interest in and allegiance to the care of the mentally ill.

Department Headquarters

The deficiencies noted within Department Headquarters may be described as (1) lack of administrative commitment to mental retardation, (2) lack of differentiation of programming between mental retardation and mental illness, (3) deficiencies in communication both vertically and horizontally, and (4) a lack of overall planning for mental retardation services. In our judgment, morale is low, especially among the professional services personnel in the Division of Hospitals. The Bureau of Research within the Research and Training Division appears to be a notable exception to the above deficiencies.

The task force recommends that Department Headquarters be reorganized along lines indicated in the organization chart on page 38. The Office of the Director should be perceived as housing the top management team of the Department, consisting of the Director and the present two Chief Deputies, one for Administrative Management and one for Program Management. The title, "Program Management" represents a recommended change from the present title, "Medical Programs." In addition, there should be an advisory committee to the Department for mental retardation.

In light of the forthcoming single state-local budget appropriation for MI services developed via the Lanterman-Petris-Short Act, and the possibility of a similar system for MR services, the task force recommends that the two current

service divisions, the Division of Hospitals and the Division of Local Programs, be abolished. Their functions should be consolidated and redistributed between a Division of Mental Retardation Services and a Division of Mental Health Services.

The Deputy Director for Mental Retardation Services should have responsibility for management and coordination of DMH services to the mentally retarded, including supervision of residential services and the review of Short-Doyle plans insofar as they contain proposals for services to the mentally retarded. The Deputy Director should be provided with professional staff assistance through units organized along functional lines, such as (1) Diagnosis and Evaluation, (2) Program Development, (3) Residential Management, (4) Community Services, and (5) Manpower Utilization and Development. All personnel in these units should be qualified in the field of mental retardation.

We believe that the above organizational model will give needed visibility to mental retardation services at the Headquarters level and focus responsibility for management of mental retardation services. We further believe that this structure will help correct the deficiencies listed earlier and will promote sorely needed planning and coordination of MR services between DMH and other organizations, both state and community.*

The task force has noted a serious salary compaction problem at Headquarters which also extends to the field facilities. The Director, Chief Deputy Director

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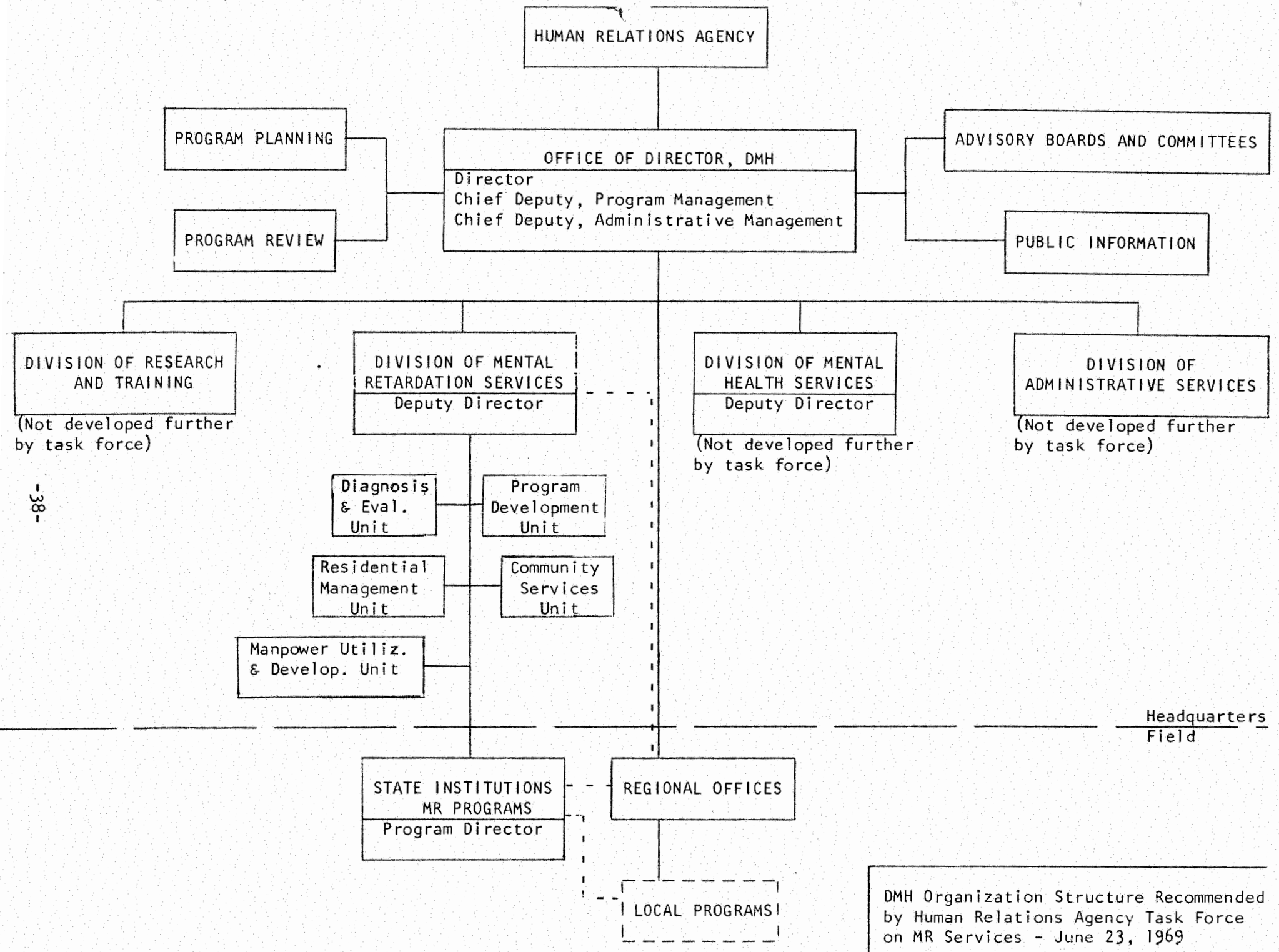
*However, we believe it is possible that <u>all</u> state services to the mentally retarded ought to be combined and established within one state department. This will be explored further by the enlarged task force in Phase II of this study.



DMH Organization Structure Recommended by Human Relations Agency Task Force on MR Services - June 23, 1969

for Medical Programs, the Deputy Directors, the Hospital Medical Directors, and Associate and Assistant Medical Directors, all receive annual salaries totaling within a few dollars of each other. This compaction results from the existing salary ceiling established by the legislature for the position of Director. The salary of the Director of Mental Hygiene should be increased significantly so as to be competitive with that of other states and with positions of comparable responsibility in and out of state government. Comparable increases should be given to subordinate positions.

DMH Institutions

Comprehensive multidisciplinary care is required for all persons in state residential facilities. This is not being achieved. The present system results in blurring of program objectives, low visibility of program achievements and failures, and dissipation of services and talents of physicians and other health care personnel. Therefore, we believe that the current hospital model for DMH institutions for the mentally retarded is inappropriate. Such a model presumes that the primary service requirement for all residents is medical treatment provided through a structure of medical management. This model is appropriate for only a portion of the current residents in institutions operated by DMH.

The task force is of the opinion that state residential services should be organized and managed along three broad classifications which characterize three rather widely differing constellations of care needs.

Type I - The first program is oriented toward medical services, mainly to persons with associated acute or chronic physical disabilities.

This would correspond to program categories B, C, and D, as listed in the SCOPE standards.[1] Hereafter we will refer to this classification as: Medical Programs for Multiply Handicapped (MPMH).

Type II - The second program is oriented toward developmental services. This would correspond to program category E in the SCOPE standards. Hereafter we will refer to this classification as: Developmental Programs (DP).

Type III - The third program is oriented toward rehabilitation and vocational services which would involve behavior modification and psychiatric care. This would correspond to program categories F, G, and H, in the SCOPE standards. Hereafter we will refer to this classification as: Rehabilitation Programs (RP).

These are broad program classifications which form a structure within which a total care program for each individual in the residential facility may be developed.

The task force believes that the overall program of mental retardation services in a DMH facility should be headed by a Program Director whose professional background is in the field of mental retardation and who has demonstrated competence in program management. He should be accountable to and receive policy direction from the Deputy Director for Mental Retardation Services at Headquarters. In a facility

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[1] "Staffing Standards for Public Mental Hospitals: Report to the Senate by the California Commission on Staffing Standards," Vol. 2, February 1967, page 19 of Appendix I.

providing services only to the mentally retarded, his position would be equivalent to that now held by a Hospital Medical Director. In a facility housing both an MI and an MR program, the MR Program Director should be at the same level as the MI Program Director.

Within the MR program there should be Program Chiefs, each accountable to the Program Director for the management of Type I, Type II, or Type III programs.* The Program Chiefs should be qualified professionals who could come from various treatment oriented disciplines, depending on the program classification for which each would be responsible.

The development and maintenance of discrete programming in keeping with the mix of persons in residence at any given time would give needed visibility to program accomplishments and failures. The chart on page 42 describes the current and recommended models.

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*See pages 53-58 for discussion of personnel and program requirements for each classification.

ALTERNATIVE CONCEPTS IN DELIVERY OF STATE RESIDENTIAL SERVICES TO THE MENTALLY RETARDED

1. Hospital Concept (Current)

   a. Resident facility perceived as a single entity (hospital) with medical services as primary service requirement of all residents in all units.

   b. Manager of each resident unit and collection of units: physician only.

   c. All residents of units are "patients" of unit manager (physician).

   d. Relationship to unit manager of specialists providing direct services to unit residents: subordinate (possibly informal colleagueship in some units).

   e. Assignment and movement of specialists: generally within specialty; movement is vertical within specialty, but generally only physicians eligible to be unit and program managers.

2. Program Concept (Recommended)

   a. Resident facility perceived as a collection of programs each serving persons with a similar major service requirement in one of three classifications.

   b. Manager of each resident unit: that person skilled in unit management and/or knowledgeable regarding the primary service requirement of unit residents, accountable to a "Program Chief" responsible for a major service area as listed in 2.a. Program Chief is responsible to the facility Program Director in charge of MR programs.

   c. All residents of unit are under supervision of unit manager.

   d. Specialists relate to unit manager as consultants. Services of various clinical specialists obtained by referral to specialty pool, e.g., medicine, dentistry, psychology, social work, rehabilitation. (Also, a management development pool should be made available to unit managers, consisting of clinical specialists or generalists with interests and capabilities in this area.)

   e. Assignment and movement of specialists: either 1) specialty pool, 2) as unit and program managers or 3) management development pool; movement possible either vertically within one of the above groups, or laterally among the groups.

Realignment of Service Areas and Utilization of Facilities Housing both MI and MR Programs

The concept of geographic service areas for MR hospitals, already initiated by the Department, is supported. However, we would vigorously oppose any effort to justify continued operation of inadequate physical plants. In our judgment, new program development should be community oriented with state hospital programs perceived as back up services. In planning for state operated MR residential beds, a formula of no more than .50 beds per thousand population should be utilized. Reduction to that level can be achieved by adequate State support for community oriented programs such as Regional Centers, Developmental Centers for Handicapped Minors, etc.

The need to reduce the distance between the institution resident and his family and community is self evident. Closer proximity will help promote resolution of communication problems and the interchange of professional services between institution and community. Most importantly, it will help identify the kinds of services that need to be developed within the communities that will promote early release and prevent chronic hospitalization.

The task force noted that residents in MR units at certain MI hospitals (Patton and Camarillo) were happier, more active, and showed better development than did persons of comparable status remaining in hospitals for the mentally retarded. With the non-physically handicapped mildly to moderately retarded adolescents and adults present in these MR/MI hospitals, the "spill-over" of staff enthusiasm, philosophy, and care techniques for the MI to the MR programs has been beneficial.

For these reasons, and only as a temporary expedient in order to relieve serious overcrowding at MR hospitals, we support the utilization of available suitable facilities on the grounds of MI hospitals for the development of MR programs, but with several safeguards: 1) program budgeting, 2) administrative assistance, 3) careful definition of roles, and 4) incorporation of recommendations on p.51 with respect to personnel utilization and development. In addition, the following guidelines should be utilized by the Department with respect to the use of facilities at MI institutions for MR programs and the assignment of geographic service areas to MR programs:

1) The development of mental retardation programs should not be approved on the grounds of MI facilities unless, and until, a written plan is developed which is approved by the Deputy Director, Mental Retardation Services specifying: a) the mental retardation program classification to be developed, b) the kinds of personnel to be recruited and trained and where training will be obtained, c) the physical facilities to be developed d) the geographic service area of the MR program, and e) the organizations within the service area to whom the MR program will relate, especially those providing screening and aftercare services.

2) No MR persons should be admitted until the appropriately trained personnel are on the job, modifications of the physical facilities have been completed, and relationships established with the appropriate community organizations within the service area.

3) Initial admissions should continue to be transferees from MR institutions, and persons should be transferred in small groups, with

staff at the facility given sufficient time to develop meaningful programs for each group before arrival of the next increment.

4) Initial plans should provide for the RP (Type III) program. If this program is successful, plans should be developed to admit persons living in the immediate vicinity of the residential facility who require DP (Type II) programs, taking into account the unique staffing and physical plant requirements for this group. Type I (MPMH) programs should not be developed at MI hospitals because of lack of appropriate facilities and personnel.

5) The four institutions for the retarded -- Sonoma, Porterville, Pacific and Fairview, should be considered the "parent" state facilities, with all three programs provided by them. Each should be linked with one or more MR/MI facilities within its geographic region. The MR/MI facility should be assigned its own MR service area within the region for direct admissions for Type III programs, thus gradually reducing the parent facility's geographic service area for that program. Also, specialized programs, e.g., blind and deaf and specialized surgery, should be concentrated in but one facility in a region.

We would envision the following relationships:

		Stages of Development		
		1st Stage Type III - RP	2nd Stage Type II - DP	3rd Stage Type I - MPM
Sonoma	Napa:	Yes	Yes*	No
	Mendocino:	Yes	Yes*	No
Porterville	Stockton:	Yes	Yes*	No
	Agnews:	Yes	Yes*	No
Pacific	Patton:	Yes	Yes*	No
	Camarillo:	Yes	Yes*	No
Fairview	Metropolitan:	Yes	Yes*	No

Phasing Out of DeWitt State Hospital

We strongly urge that DeWitt State Hospital be phased out as a facility for the mentally retarded. Where possible, present MR residents in DeWitt should be placed in community facilities; those requiring state residential care should be transferred to other state facilities. In the opinion of the task force, closure of DeWitt's mental retardation unit would result in substantial savings for the State in the future.

The number of retarded persons at DeWitt as of January 1, 1969, was 851. According to DMH figures, if funds were available 15% (128) could be placed in community facilities. The Departments of Mental Hygiene and Social Welfare should expedite placement of these individuals into community facilities. This would leave about 720 persons who currently need hospital care. By not admitting any

*Envisioned only for the geographic area immediately adjacent to the state facility. For example, Mendocino State Hospital would develop Type II programs for persons coming from communities in Mendocino County.

new residents to this facility, the population in 1974 would be about 550 because of resident turnover due to leave of absence, movement out of the State, deaths, etc., if one applies an estimate of 5% per year reduction due to these causes. This is a reasonable expectation based on past experience.

As of February 28, 1969, according to DMH Bureau of Biostatistics figures, 2% of DeWitt's population came from the Fairview catchment area; 5% came from the Pacific area; 33% came from the Porterville area; and 60% came from the Sonoma area. If one assumes that this present ratio is maintained, it is estimated that in 1974, of the 550 residents, 11 would be from the Fairview area, 28 from the Pacific area, 171 from the Porterville area, and 340 from the Sonoma area. (See chart on page 49 .)

The Department of Mental Hygiene should request that the Alta California (Sacramento), San Jose, Fresno, Los Angeles, San Diego, and Golden Gate (San Francisco) Regional Centers give priority for service wherever possible to retarded persons remaining at DeWitt whose residence is in the area served by them. Based on prior experience at Pacific, Regional Centers could provide service to at least 20% of this population if adequate funding were made available for purchasing residential care from private residential facilities.

The remaining 440 residents at DeWitt presumably would still require state hospitalization. Those from Southern California should be transferred to Camarillo and Patton State Hospitals. This would leave 409 retarded persons at DeWitt (137 from the Porterville service area and 272 from the Sonoma service area). One hundred twenty-five should be transferred to Agnews and an equal number to Mendocino State Hospital when space becomes available, leaving 159

who could be transferred to Napa State Hospital. The task force recognizes that the effort to relieve overcrowding by transfer of patients from Sonoma and Porterville to MI/MR hospitals will be delayed by closure of DeWitt in this manner.

New innovative models of care, already proven successful in other countries[1], must be developed to serve Northern California, preferably in new locations near or in Redding, Chico and Sacramento, in concert with the recommendations in the Quality of Life Section of this report. Development of such services would assist in the closure of DeWitt.

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[1] Nirje, Bengt, op. cit.

PROPOSED DEPOPULATION OF DEWITT STATE HOSPITAL
-- MENTALLY RETARDED RESIDENTS

	Total	So. Calif. Area	Porterville Area	Sonoma Area
Disposition of residents (2/28/69 Census)	837	58	263	516
15% reduction via referral to Community Services Division of State Department of Social Welfare	128	8	40	80
20% reduction via normal turnover	159	11	52	96
TOTAL REDUCTION: 1969-74	287	19	92	176
REMAINING POPULATION: 1974	550	39	171	340
20% reduction of remaining population via Regional Centers	110	8	34	68
Transfer of remaining residents to other state hospitals	440	31 (To Camarillo & Patton)	137 (To Agnews & Napa)	272 (To Napa & Mendocino)

Parental Permission for Placement

All hospitals have some staff members who are concerned about the question of parental permission for placement. In our opinion, a policy of parent permission acts as a check and balance on possible premature or ill-advised placements. Having to answer a parent's questions contributes to a careful review of the purpose of the placement within the long range management plan for the child and review of the quality and nature of the program into which placement is proposed. However, we were presented a small number of examples of situations where unquestionably a well-advised placement much in the child's interest had been refused by a parent. Some sort of appeal procedure to an impartial panel outside of the hospital structure, including a consumer representative, should make it possible to adjudicate differences between staff and parents regarding placement, to the best interest of the mentally retarded person.

PERSONNEL UTILIZATION AND DEVELOPMENT

RECOMMENDATIONS

For Action by the Director of Mental Hygiene

20. Basic Care personnel in Medical Programs for the Multiply Handicapped (Type I) should be licensed vocational nurses (LVN) and registered nurses (RN).

21. Basic care personnel in Developmental Programs (Type II) should be child development aides and child development specialists.

22. Basic care personnel in Rehabilitation Programs (Type III) should be psychiatric technicians.

23. Promotion, retention, and merit salary increases for physicians in MR programs should be based primarily on a critical annual review of performance as demonstrated in a clinical setting for the mentally retarded, irrespective of specialty background of the physicians.

24. Basic residency programs for physicians should be continued for psychiatric programs and extended to pediatrics, emphasizing mental retardation and related handicapping conditions.

25. More opportunity should be given all basic care personnel for upward mobility into various management and professional classes in order to fill manpower needs.

26. Basic training for the various basic care personnel should occur in Junior Colleges with DMH providing stipends and field practice settings.

DISCUSSION

The Present Staffs Are Missing Their Mission

It is urgent that the staffs of the hospitals re-examine and clarify their objectives and goals. The objectives and goals must be realistic in recognizing the effect of modern treatment and management techniques for the retarded and the impact of a variety of community programs on the type of resident to be served by the hospitals. The role of DMH institutions now and in the future will be determined by the type of resident they have which, in turn, will be influenced by the multiplicity of programs developed and to be developed outside of the institutions. The broad spectrum of types of persons with retardation in state hospitals and the widely divergent care needs require personnel within most of the professional and basic treatment and care classes to have differing skills, interests, and backgrounds. Our recommendations as to manpower for treatment are based on the three constellations of service programs described earlier on page 39 which we believe will continue to be representative of the program needs of the resident mix in varying proportions. We strongly urge the introduction of a wide variety of personnel into basic care services. Included among the personnel would be licensed vocational nurses, developmental aides and specialists, and rehabilitation and vocational specialists in addition to psychiatric technicians.

Most basic on-ward care is now given by psychiatric technicians. The heavy emphasis on psychiatric nursing in the training program of psychiatric technicians and the climate of psychiatric nursing in the hierarchy of nursing service

organization in the state hospitals has produced the problem of having basic care personnel in many situations with inappropriate skills and expectations. We believe that the expectation of doing something different than reality dictates is in part responsible for the turnover of new psychiatric technicians and psychiatric technician trainees in hospitals for the retarded.

Basic Care Personnel for MPMH (Type I)

The Medical Programs for the Multiply Handicapped will be serving primarily severely and profoundly retarded persons. They are in need of hospital care given by personnel trained in medical and nursing skills and attitudes. Basic care for this group would best be given by licensed vocational nurses (LVN) who have had around six months of additional part-time on-the-job training in the special skills needed to handle the multiply handicapped. We believe the curriculum for this additional training should be taken within one year of first employment. The curriculum should include material on 1) etiology and types of mental retardation, 2) the cause and management of commonly associated disorders, such as cerebral palsy and convulsions, 3) pediatric nursing, 4) child and infant development, 5) nutrition as it relates to the mentally retarded and physically handicapped, 6) epidemiological factors in group living, 7) an understanding of the organization of community and state services for the care of the retarded, 8) recognition of symptoms of serious illness in infants and children, and 9) techniques of relating to and understanding the problems of parents of retarded children.

Supervision of LVN's would be given by registered nurses. Provision for the inservice training of registered nurses is essential, particularly for those with associate degrees, to give them the special skills needed in pediatric

and geriatric nursing to work with severely retarded patients with multiple handicaps.

Personnel presently employed as psychiatric technicians who wish to continue to work in MPMH should be provided education to qualify them as LVN-MR specialists; some psychiatric technicians with experience in Type I programs who presently do have LVN certificates should qualify as LVN-MR specialists without further training; and others who have potential as supervisors or as nurse specialists should be provided educational opportunity to qualify as registered nurses.

A typical ward nursing staffing pattern would include the following kinds of personnel:

RN (Charge)

RN or possibly LVN-MR Specialist II (Assistant Charge)

LVN-MR Specialist II

LVN I

Clerk

Housekeeper (Hospital Worker Classification)

This should not preclude inclusion of child development aides or specialists or psychiatric technicians when their skills would promote comprehensive care. Since there is not a complete dichotomy between MPMH (Type I) programs and the other two program types, some overlapping of personnel classes and even sharing of services will be required among programs. We envision, for instance, that in an MPMH (Type I) program for young children, there may be some need for the special skills of child development specialists or aides

even though LVN-MR specialists II will have basic training in child development. In such cases, a ward having an MPMH (Type I) program with predominantly RN and LVN staffing might have one or more child development personnel. Similarly, an adult living unit with a Type I program might include one or more psychiatric technicians on its staff.

Basic Care Personnel for DP (Type II)

The Developmental Programs will be serving primarily non-physically handicapped individuals, including those who are severely retarded, who have basic program needs which emphasize promoting development, sensory-motor training, socialization, behavior shaping, habit training, and education and nutrition within capability of their level of development. Most important of all, they need to develop consistent one-to-one relationships with adults and sibling-like relationships within small peer groups.

Type II programs would be better located in a setting which would be modeled on child care centers, nursery schools, and on developmental and special education techniques. Therefore, the basic care personnel for DP should not be trained in a nursing model. Attitudes and expectations toward child care would more appropriately be similar to those of nursery school teachers, teacher aides for special education classes, and child care workers. This would not preclude working with adolescents or adults in need of such programs.

We would recommend that two new classes be established titled: Child Development Aide and Child Development Specialist. Educational requirements for Child Development Aide would be an associate degree or its equivalent granted after a training program including study of normal and abnormal child development,

techniques of promoting motor and sensory skills in children, basic methods in special education, elementary psychology, sociology, use of the English language, and some liberal arts courses. Also required should be a course in home economics which would include basic child care skills and elements of nutrition.

Eligibility for the class of Child Development Specialist would be achieved following about six months of part-time on-the-job training in 1) advanced child development, 2) programming for the mentally retarded, 3) development of leadership skills, 4) techniques of relating to and understanding problems of parents of retarded children, 5) an understanding of the organization of community and state services for the care of the retarded, and 6) recognition of symptoms of illness in infants and children.

Psychiatric technicians who, on establishment of these classes, have had one year of experience in Type II programs should be blanketed into the class of Child Development Aide, if they so request. Educational opportunity should be provided for psychiatric technicians who become Child Development Aides to qualify as Child Development Specialists. Some might so qualify by examination alone and/or by previous experience in leadership roles.

Supervision would be given to Child Development Aides and Specialists by a cottage manager. A typical cottage staffing pattern would include the following kinds of personnel:

Child Development Specialist III (Cottage Manager)

Child Development Specialist II (Assistant Cottage Manager)

Child Development Aide I

Clerk

Housekeeper (Hospital Worker Classification)

Medical, nursing, and other health services would be provided by an outside team similar to that of a child in his own home. Rehabilitative services also would be available.

Basic Care Personnel for RP (Type III)

The Rehabilitation Program will be serving primarily those persons without major physical handicaps still in hospitals who need mainly a sheltered living situation, various levels of vocational opportunity, recreation, and continued training in social skills and good grooming. Some suffer from dehumanization resulting from prolonged institutionalization given in a mass care setting. Although most of them would be best served by programs in the community, it is not realistic to expect that these community opportunities will be available in sufficient numbers in the near future. Therefore, some of these persons will be in state institutions for some period of time. There are other persons in the hospitals who, in addition to having mental retardation, have emotional problems and sometimes concurrent psychoses. Many of them have only mild to moderate degrees of retardation.

Type III programs require basic care personnel who are skilled in vocational training, behavioral modification techniques, motivation and remotivation; who have a background in psychology and psychiatric nursing techniques; and who understand sociocultural factors in mental retardation.

We recommend that psychiatric technicians be used for giving basic care in Type III programs. We recommend some modification in the present training

program for psychiatric technicians to emphasize rehabilitation and vocational training skills. We further recommend that psychiatric technicians in the future receive their basic training in two-year colleges and that the associate degree or its equivalent be considered the minimum entry level.

Supervision would be given by higher levels in the psychiatric technician series. A typical unit staffing pattern would include the following kinds of personnel:

Psychiatric Technician - MR Specialist III (Unit Manager)

Psychiatric Technician - MR Specialist II (Assistant Unit Manager)

Psychiatric Technician I

Clerk

Housekeeper (Hospital Worker Classification)

Medical, nursing and other health services would be provided by an outside team similar to that of a person living in his own home.

Medical Services

Although there are some outstanding exceptions, the medical staffs working in the institutions for the mentally retarded are largely untrained in the fields of mental retardation, administration and program leadership. It is our belief that mediocrity tends to attract mediocrity and drive away excellence; therefore, we believe the present situation among the medical staffs presents a very serious problem which can only be corrected by a variety of means within the context of improved programming, adequate levels of support, and changes in organization as we have recommended elsewhere. We strongly recommend that promotion, retention, and merit salary increases for physicians in MR programs should be based primarily on a critical annual

review of performance as demonstrated in a clinical setting for the mentally retarded and irrespective of specialty background. Inservice training programs must be offered which are of variety and depth in mental retardation and clearly related fields and which are directed toward preparing the medical staffs to do their job. All physicians should be encouraged to attend post-graduate training programs and conferences in and out of state which would better prepare them for work with problems of mental retardation. We believe that the problem of recruiting well-trained, innovative physicians can be alleviated through competitive salaries, more meaningful programs, better administrative organization, the presence of a research atmosphere, and the encouragement of medical school affiliations.

The psychiatric residency training programs operated by the Department of Mental Hygiene have not met the major needs of physicians at the hospitals for the mentally retarded. In part, this is because much of traditional psychiatric training is inappropriate for work with the moderately to severely retarded and especially with the multiply physically handicapped group. Graduates of traditional psychiatric training therefore do not find the work in hospitals for the retarded satisfying or making maximum utilization of their skills. Graduates of the Department's psychiatric training programs have tended not to go to state hospitals for the retarded and, when they have done so, have not generally remained.

The Department's training programs have not attempted to meet the needs for well-trained physicians to care for the increasingly large proportion of children and multiply handicapped. The Department must recognize this need, which is rapidly becoming as great as their need for traditional psychiatrists

to work with the mentally ill. The mentally retarded now make up 42 percent of the total population in state hospitals. We believe that DMH should support appropriate basic training for physicians to meet this need. In addition to the psychiatric training program, we recommend that the Department support training programs in pediatrics. We also believe that child psychiatry should receive greater emphasis in the present training programs. The Department should combine efforts with medical school pediatric and psychiatry departments through support of faculty coordinators between medical school departments and state hospitals. Residency stipends should be considered. The Department's facilities for clinical training should be made freely available to medical schools and appropriate teaching hospitals. The development of university affiliated demonstration centers is recommended. In this manner, DMH should be better able to meet some of its physician manpower needs.

Other Professional Services

We find that the hospitals for the retarded have had more success in attracting social workers competent to do the job required with the mentally retarded than they have had with physicians. We speak here not of success in recruiting numbers, but in recruiting professionals who are capable. Recruitment of adequate numbers is still a problem and we expect it will become increasingly more difficult as more and more community opportunities compete with the hospitals for the manpower pool.

We interviewed a few clinical psychologists who were dedicated to working with the mentally retarded and who, in addition, were imaginative in programming for them. Many other clinical psychologists had not had training in mental retardation or experience in progressive programs for this group. The problem

may be, in part, a result of the fact that Ph.D. programs preparing clinical psychologists do not offer practicum training in clinical facilities having a broad variety of clinical problems in mental retardation. The Department of Mental Hygiene and other state agencies with programs in mental retardation should aggressively promote themselves as clinical training resources for the clinical psychology training programs in California.

Teachers of the mentally retarded are difficult to recruit because of limited numbers available in the manpower pool and because working conditions in state hospitals compare unfavorably in some respects with working conditions in public schools. There was some evidence that the problem of job expectations (especially the fact that professional interests and background are inconsonant with the challenges presented by the trend toward more serious degrees of retardation and toward an increasing proportion of physically handicapped) is more severe among the teacher group than with any other professional group except the psychiatrists. We believe that an opportunity for upward movement by subsidized college and university work for basic on-ward and cottage care personnel would likely produce the kind of teachers needed.

We recommend competitive salaries, more meaningful programs, better administrative organization, a research atmosphere and university and college affiliations in a variety of professional fields in order to improve recruitment and retention of social workers, clinical psychologists, and teachers of the mentally retarded, and also other professional classes such as various kinds of rehabilitation specialists, physical therapists, and dentists.

Especially in these fields, we recommend the use of other than professional classes such as social work associate and assistant, teacher assistant,

psychometrist and psychology assistant, and physical therapy aide in order to achieve more effective use of rare, fully qualified professional talent. The recruitment to these classes and the opportunity for advancement to full professional standing from ward and cottage level care personnel will have other advantages as discussed in the section on Upward Mobility.

Central Office Recruitment

Department Headquarters has very few professionals in leadership roles who are knowledgeable in the field of mental retardation or who have had specific experience in developing programs for the mentally retarded. Reorganization of Headquarters, as we have recommended, with the formation of a mental retardation division, will present serious problems in obtaining competent professionals. However, we believe that the reorganization proposed will make the administrative structure one which will be more attractive to persons specializing in mental retardation than is the present one. There is, in addition, a serious problem of salary compaction at the upper administrative levels which is preventing payment of competitive salaries. We recommend that the compaction problem be relieved and higher salaries be paid for rare professional skills irrespective of administrative level.

In order to obtain knowledgeable staff people for the proposed division of mental retardation, we recommend separate classes in the various functional units so that knowledge and skills specifically in mental retardation, as contrasted to a background with mental illness, be assured for this division.

Interchange of Personnel With Community Programs

Earlier in this report, we identified problems of job expectations and skills that are inappropriate for the job to be done as a result of the trend in

the hospital population toward more severe degrees of retardation and an increasing proportion of multiply physically handicapped individuals. We have recommended for those employees who are inappropriately trained for the job to be done, that one solution is retraining. However, we also anticipate an increasing opportunity for employment of these individuals in programs outside of the hospitals. The overall distribution of types and levels of retardation in the total community is not changing markedly. Therefore, retarded persons who were previously in hospitals are and will be in community programs. We suggest that it may be easier in many cases for employees to move to community programs where they can use their present skills rather than go through retraining with its changing expectations in order to continue working in a state hospital.

Department efforts toward training and retraining of personnel for work with higher levels of retarded persons (in Type II and III programs remaining in state hospitals) will have the potential effect of establishing a reservoir of urgently needed personnel for expanding community programs in California and elsewhere.

Upward Mobility

The Department, in its hospitals, has recognized in a limited manner the need for upward mobility of its employees. One very excellent program which has been applied on a too limited basis to meet the hospital needs, is that for psychiatric technicians to become qualified as registered nurses with associate degrees. Also, the recent establishment of a class of social work associate with opportunity for upward mobility of psychiatric technicians to these positions is another excellent example of such a program. We would strongly

urge that these programs be continued and strengthened and that other programs be developed.

Upward mobility will have the distinct advantage of producing qualified persons with demonstrated interest and commitment to working with the mentally retarded. We also believe they will seek out those areas especially relevant to working with mental retardation while in their educational programs.

Figures on the following pages diagram for each of the program types, our proposals for the sources of original recruitment and the opportunities for upward mobility within the proposed basic personnel care classes. Opportunity for upward mobility from these classes to professional classes will, we believe, attract more highly qualified and motivated basic care personnel to the Department. It will also relieve one of the sources of discontent among present employees in the hospitals, especially as seen in the psychiatric technician group. The further advantage of upward mobility programs is as a major recruitment source for filling the needs of California and the nation for professional personnel.

DESCRIPTION - TYPE I FLOW PATTERN FOR UPWARD MOBILITY OF PERSONNEL

High school graduates would enter LVN programs in junior colleges. These programs would have to expand their enrollment to meet the Department of Mental Hygiene's needs. A scholarship for students is recommended at least in the initial stages of the program in order to insure adequate enrollment in expanded programs. DMH clinical facilities should be made fully available to assist the junior colleges with their programs. On obtaining LVN licenses, persons in these programs could enter employment as LVN I. LVN's licensed through other than public junior college programs, i.e., from private schools, technical high school programs, and through training received as medical corpsmen in military service, would also enter at the level of LVN I.

An LVN with satisfactory completion of about six months of a part-time inservice educational program (major curricular elements described on page 53) would qualify as an LVN-MR Specialist II. Hopefully, junior college credits could be earned from this training program. LVN-MR Specialist II would be the journeyman level for Type I programs.

Many would prefer to remain at this level. Others with demonstrated ability and potential for continued service with the mentally retarded might wish to continue upward along one of several pathways.

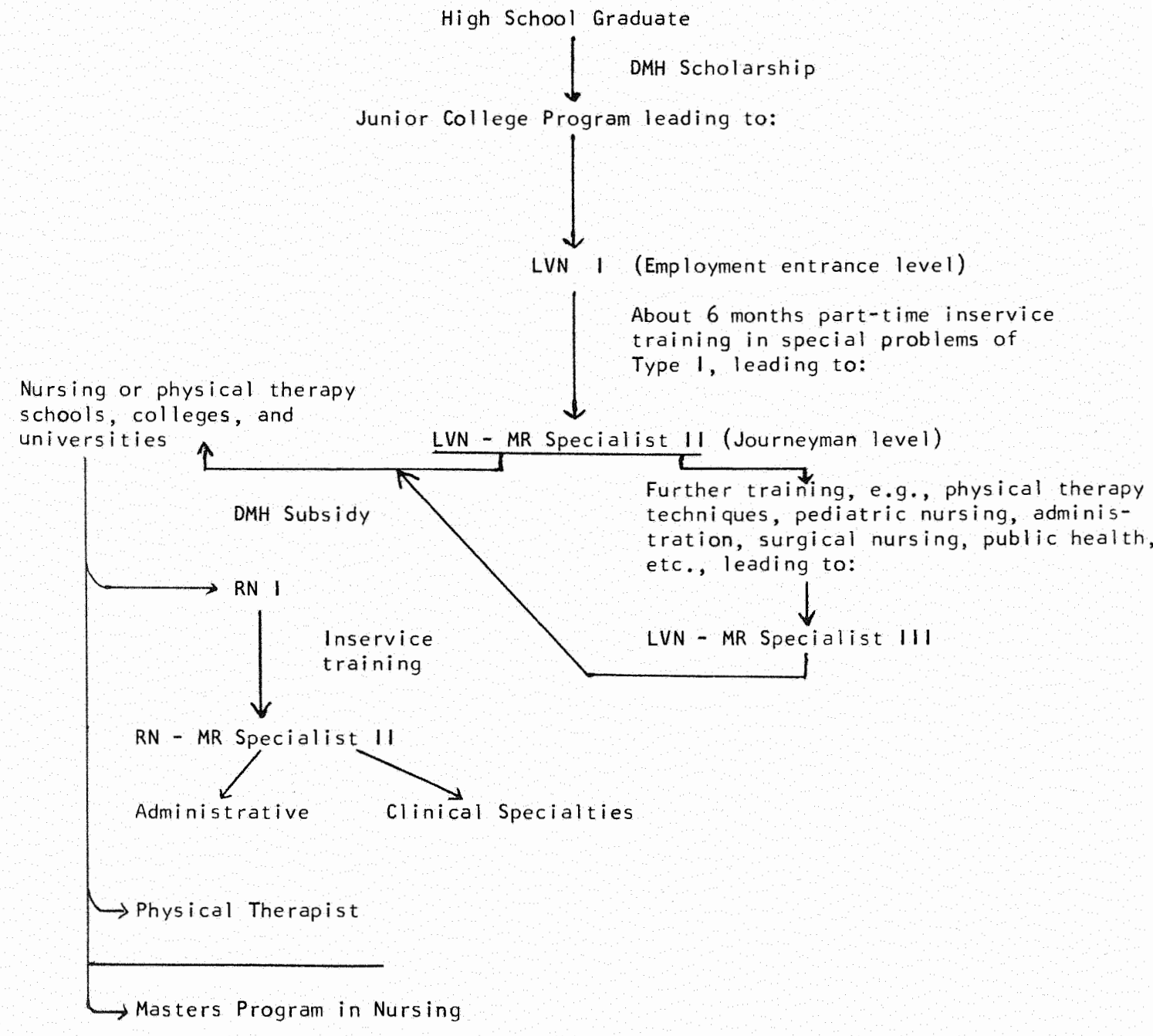
One pathway would be to go through an associate degree or baccalaureate degree nursing program with DMH subsidy and return to Type I program as a registered nurse. Upward mobility could continue through qualifying for administrative positions or through higher grades of clinical specialist positions.

Others might wish to remain as LVN's but through further inservice training qualify as physical therapy aides or as LVN clinical specialists or qualify for administrative positions.

Others could receive further academic training to become fully qualified physical therapists.

TYPE I

(Medical Programs for Multiply Handicapped)



DESCRIPTION - TYPE II FLOW PATTERN FOR UPWARD MOBILITY OF PERSONNEL

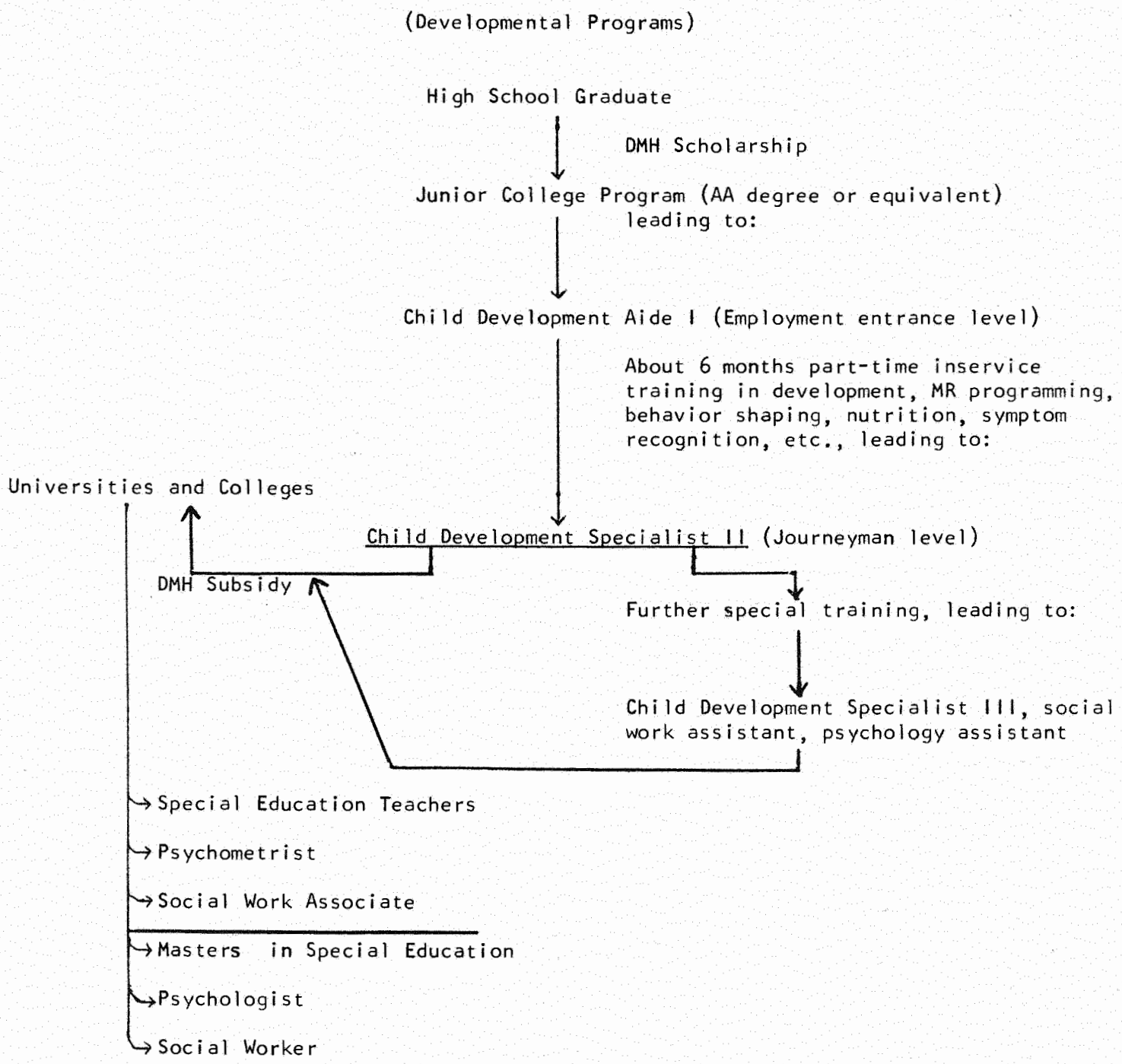
Child development programs would be encouraged in the public junior college system. Such programs have not previously existed in junior colleges in California. Initial impetus for the development of such programs would require some assurance of students through a scholarship program at least in the initial stages, through legislative direction and program subsidy, and assurance by DMH that graduates of the programs would be employed.

High school graduates would pursue a two-year curriculum in child development leading to an associate degree or its equivalent. The basic curricular elements of the proposed educational program are described on page 55 . The two-year program in child development would qualify a person to enter the system as a Child Development Aide I.

Satisfactory part-time inservice training over approximately a six-month period would permit a Child Development Aide I to become a Child Development Specialist II. This would be the journeyman level of personnel for Type II programs.

Highly motivated child development specialists with demonstrated ability could, with further inservice training, qualify as cottage managers or as social work or psychology assistants. Others with DMH scholarships could pursue further academic work in colleges and universities leading to baccalaureate degrees and qualification as psychometrists, teachers, or social work associates. Further training at the graduate level could lead to fully qualified professional status as social workers, psychologists, or master level teachers in special education.

TYPE II


(Developmental Programs)
High School Graduate
DMH Scholarship
Junior College Program (AA degree or equivalent) leading to:
Child Development Aide I (Employment entrance level)
About 6 months part-time inservice training in development, MR programming, behavior shaping, nutrition, symptom recognition, etc., leading to:
Universities and Colleges
Child Development Specialist II (Journeyman level)
DMH Subsidy
Further special training, leading to:
Child Development Specialist III, social work assistant, psychology assistant
Special Education Teachers
Psychometrist
Social Work Associate
Masters in Special Education
Psychologist
Social Worker

DESCRIPTION - TYPE III FLOW PATTERN FOR UPWARD MOBILITY OF PERSONNEL

Psychiatric technology programs would be encouraged in the public junior college system. Impetus for development of such programs would require some assurance of students through a scholarship program at least in the initial stage, through legislative direction and program subsidy, and assurance by DMH that graduates of the programs would be employed.

High school graduates would pursue a two-year curriculum in psychiatric technology leading to an associate degree or its equivalent. The basic curricular elements of the present psychiatric technician training programs would be modified by an increased emphasis on rehabilitation techniques and vocational training skills and a decreased emphasis on nursing arts. The two-year program in psychiatric technology would qualify a person to enter the system as a Psychiatric Technician I.

Satisfactory part-time inservice training over approximately a six-month period in theory and application of behavior shaping techniques, advanced rehabilitation and vocational training skills, development of leadership skills, and understanding of the organization of community and state services for the care of the retarded would permit a psychiatric technician to become a Psychiatric Technician-MR Specialist II. This would be the journeyman level of personnel for Type III programs.

Highly motivated psychiatric technicians-MR specialist II with demonstrated ability could, with further inservice training, qualify as unit managers or as social work, psychology, or rehabilitation assistants. Others with DMH scholarships could pursue further academic work in colleges and universities leading

to qualification as psychometrists, social work associates, rehabilitation therapists, or vocational counsellors; and with further education, to qualify as psychologists or social workers.

TYPE III

(Rehabilitation Programs)