Part VI: Model Service Models

Chapter 13

A Densely Populated Small State: Connecticut

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A DENSELY POPULATED SMALL STATE: CONNECTICUT [1,2]

Services for the retarded in Connecticut have, for many years, enjoyed a well-deserved high reputation. Indeed, this state's program has been held up as a model worthy of emulation by others. There is a certain irony in this fact, for the only constant in Connecticut's services for the retarded is continuing experimentation and change. If there is one concept which underlies all developments here, it is the notion that today's services for the retarded are better than yesterday's, but inferior to tomorrow's. Therein lies Connecticut's greatest strength. The description of the system today (in early 1968) is therefore merely a static picture of a dynamic force, more analogous to a snapshot of a runner in motion than to an architectural blueprint of an imposing edifice. Even as these lines go to press, much will have changed already in the services, the techniques, and perhaps even "the philosophical approaches to this treatment of the retarded."

The Origins of the Connecticut Program

Current events are best understood in terms of their developmental history. An individual reflects the sum total of his cultural background, his social relationships, and his personal experiences. Governmental systems can only be understood in terms of the very special history each of them accumulates, and the specific circumstances which have led up to present practices. Since each system's background and setting are unique, it is impossible to transfer a working model from one locale to another without seriously considering the necessary changes associated with such a transfer.

Connecticut is a compact, densely populated state. In area it ranks forty-eight among the fifty states, yet it is fourth in population destiny. The people of Connecticut are generally affluent, ranking first in per capita personal income; they are relatively well educated, ranking in second place in the number of Ph.D.'s per million population and first in percentage of high school juniors scoring in the top 6 percent of those taking the National Merit Scholarship examinations. Manufacturing of sophisticated equipment (e.g., airplane engines, submarines)

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and other industrial enterprises are the major source of the economic prosperity. Farming is relatively unimportant.3

While the overall economic and educational situation of the majority of the close to three million inhabitants of the state is a favorable one, the state has not escaped the problems of urban blight, regional unemployment, and individual hardship. The two major cities, Hartford and New Haven, have segregated ghetto areas, and some of the relatively remote rural sections have experienced considerable hardships due to the migration of indigenous industry to southern states.

Connecticut is proud of its New England heritage, and although its population is no longer predominantly Anglo-Saxon Protestant, it has retained the philosophy of individualism and self-reliance characteristic of its Puritan settlers. Town government is the mode of government. Politically, 169 independent towns maintain separate services for their inhabitants (including 169 separate school systems), and reliance on statewide social services is only reluctantly accepted as a necessary evil. The people in Connecticut want and enjoy close contact with their elected and appointed officials, and view their close relationship with government as an intimate right. This kind of setting, whatever its weaknesses, is especially receptive to the creation of regional, community-based services.

The origins of the current approach were, however, not dissimilar to national trends in mental retardation. During the early 1900's, mentally retarded and epileptic persons were segregated in a colony, and in 1917, Connecticut's first permanent "State Training School and Hospital" was established. This facility was essentially a medically-oriented agency which offered medical treatment and custody on a thousand acre lot, located in a then most inaccessible area of eastern Connecticut near the town of Mansfield.

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[3]Figures derived from Connecticut Market Data, 1968, Connecticut Development Commission, State Office Bldg., Hartford, Connecticut.

[4]Connecticut had a privately supported institution since 1830, at which time a physician, Dr. Henry M. Knight, opened a small facility in his own home. In 1861, Dr. Knight founded a "School for Imbeciles" in Lakeville and incorporated it. Ownership of this facility was assumed by the state of Connecticut in 1913.

In 1907, the legislature called upon the governor to establish a "Colony for Epileptics." Evidently little came of this statue, and in 1909, the legislature enacted a statute calling for the establishment of a "Colony for the Treatment of Epileptics and Feebleminded." to be located in Mansfield. This facility was consolidated with the Lakeville institution and commenced operations in 1917 under the name of "The Mansfield State Training School and Hospital."

As the need for admission to this medical facility increased in the mid-1930's, the legislature nominated a commission to explore possible alternatives. One alternative was the expansion of bed space at the Mansfield facility. This tack would have been a relatively cheap one. Its major drawback was the great distance of this **hospital** from the population centers located in the western part of the state.

Instead an alternate plan was considered, and it was decided that a second facility be erected. This new facility was to include in its catchment area the western half of the state (regardless of the type or nature of the retardation), while the Mansfield facility was to remain responsible for the eastern part of the state.

While in 1917 the most progressive thinkers conceptualized mental retardation treatment largely in medical terms, in 1937 a more pedagogical approach was emerging. The second facility to be erected in Connecticut was designed primarily for training and educational purposes. Its name was to be "training school," and not "hospital"; its philosophy was to be educational. The superintendent of the new Southbury Training School was to be an educator. Mr. Ernest Roselle was appointed to this post. Mr. Roselle believed in creating a setting which was to simulate home conditions as much as possible, and designed Southbury according to a "cottage plan" in which small units would house limited numbers of retarded youngsters, cared for by "cottage parents." These married couples were to regard the cottage residents as their extended family. In time, the Southbury Training School became to be regarded by many as the model facility among state-supported institutions in the United States.

While the two large facilities in the state stressed internal development (improved care, education, medical treatment, and additional bed space), in the 1950's, local pressures brought about the creation of new resources for the retarded outside the institutional settings. Community facilities began to be developed by local towns and by the parent groups without assistance from the state government. Special classes for educable and trainable retarded children were established in several of the more affluent school systems, sheltered workshops and day-care facilities sprouted here and there, and in 1953 the state legislature permitted reimbursement to towns who desired to serve retarded children through school systems, although education for the retarded was not yet mandatory.

It became increasingly apparent to the professionals in the field and to the parents that the existence of uncoordinated and autonomous approaches to retardation was not fulfilling the needs of the mentally retarded and that a reappraisal of the entire concept of service was in order. This re-thinking led to the current operational model in Connecticut: the regional program.

A Continuum of Services: the Regional Program

The basic assumption underlying the service approach to mentally retarded persons is rarely if ever expressed in Connecticut, yet it is implicit in the model and the philosophy: no institution can be as good as a good home. A corollary to this tenet is the operational maxim: let us do all we can to extend all services to the family so that retarded children and adults will remain in the community and in the home. This philosophy is not only based on ample research evidence but also, and perhaps mainly, on the basic human impulse to retain a child at his parents' side.

A basic shift in the philosophy of care necessitated a fundamental modification of administrative structure. Independently functioning, self-contained institutions led by autonomous superintendents, are incapable of establishing services which are responsive to community needs. A new authority with administrative powers was needed. This authority was established by statute in 1959 in the form of the Office of Mental Retardation.5

The Office of Mental Retardation

The Office of Mental Retardation was established within the framework of the Department of Health, which had hitherto been responsible for public health and maintained a number of chronic disease facilities. It was felt that the mentally retarded would fare better if not included with psychiatric facilities, which in Connecticut are the responsibility of the Department of Mental Health. The office was to be administered by a Deputy Commissioner who would act upon the advice of a "council on mental retardation." His task was clearly spelled out in the law: "he shall be responsible . „ „ for planning and developing a complete, comprehensive and integrated statewide program for the mentally retarded." His responsibilities also included the "coordination of the efforts of the Office of Mental Retardation with those of other state departments and agencies, municipal governments and private agencies concerned with and providing services for the mentally retarded." The intent of the statute was to lay a framework for a continuum of statewide services extended to all the mentally retarded and not only to those in residence at a state facility.[6]

The Administration of Connecticut's System

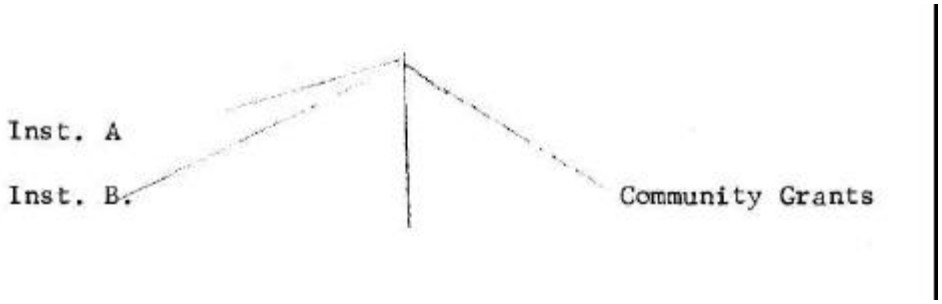
Emerson once said, "An institution is nothing but the lengthened shadow of one man." I am not sure that this aphorism reflects on an entire program of political action, but it certainly has some bearing on Connecticut's retardation model. Each of the institutions in this state bear unmistakably the mark of its original administrator, and the entire program the hallmark of its executive head.

At the same legislative session, a statute requiring public school systems to serve both educable and trainable retarded school-age children was passed.

[6]Quotations are from 1959 Statutes„ See Appendix.

It appears that institutional systems are exceedingly slow to change and that it is therefore much easier to erect a new system to than to change an old one. In Connecticut, it was possible to fit the old and the new models into one framework. The first institution was medical in design (the Mansfield State Training School and Hospital); when its concept was superceded oy a pedagogical model, it was not revamped, but instead another institution, the Southbury Training School, was established. Both facilities functioned together and served the state's population, though each was quite different in its conception.

Today, still another approach is taken: regional services based on a partnership between communities and state government. The two large institutions will, however, continue to function within the same framework as do the smaller centers. This is accomplished through relative regional autonomy, guided by central rules. In fact, the central office administers three separate but interdependent systems (see Fig. 1).



Central Office

Regional Centers

Figure 1

The superintendents of the two large (1,800 and 2,000+ beds respectively) facilities are directly responsible to the Deputy Commissioner. The regional centers, small in bed capacity (maxium 250 beds), are relatively less autonomous than the two large institutions. The third arm of the central office administers grants-in-aid to parent groups, clinics, and other community agencies.

The three arms of the system are thus independent of each other and permit a substantial amount of administrative flexibility. The actual table of organization is of course much more complex than indicated in Figure 1. It relates to many other state services within and without the State Department of Health. Citizen councils and advisory boards are active at all stages (See Fig. 2). It must be borne in mind, however, that people do not interact according to tables of organization, but in terms of personal interests, friendships, and idiosyncratic aversions. No sociogram of these real relationships is available to this author. The human qualities of interpersonal relationships, though uncharted determine the success or failure of a program.

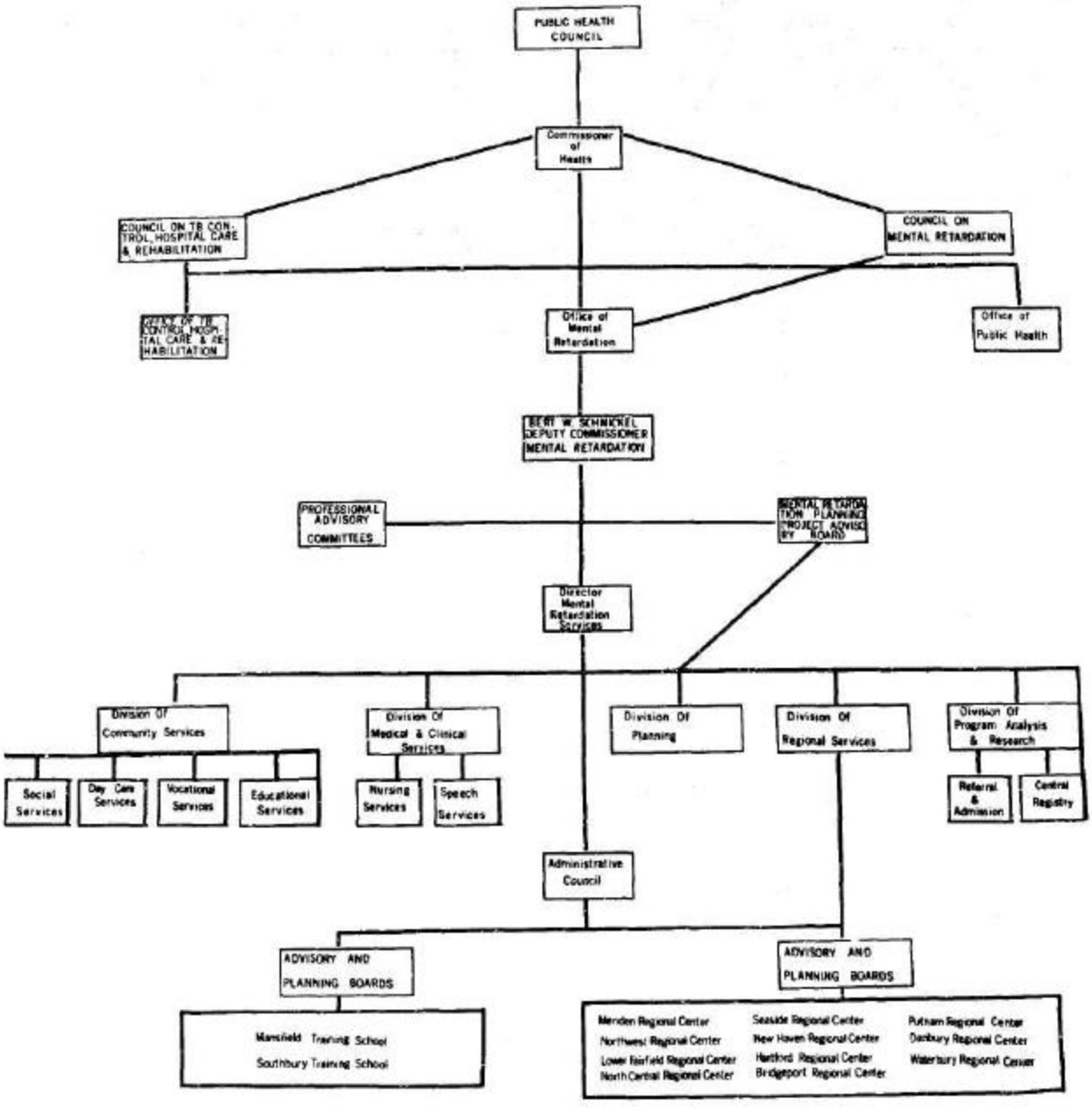

PUBLIC HEALTH COUNCIL
Commissioner of Health
COUNCIL ON TB CONTROL, HOSPITAL CARE & REHABILITATION
COUNCIL ON MENTAL RETARDATION
OFFICE OF TB CONTROL HOSPITAL CARE & REHABILITATION
Office of Mental Retardation
Office of Public Health
BERT W. SCHNICKEL DEPUTY COMMISSIONER MENTAL RETARDATION
PROFESSIONAL ADVISORY COMMITTEES
MENTAL RETARDATION PLANNING PROJECT ADVISORY BOARD
Director Mental Retardation Services
Division Of Community Services
Social Services
Day Care Services
Vocational Services
Educational Services
Division Of Medical & Clinical Services
Nursing Services
Speech Services
Division Of Planning
Division Of Regional Services
Division Of Program Analysis & Research
Referral & Admission
Central Registry
Administrative Council
ADVISORY AND PLANNING BOARDS
Mansfield Training School
Southbury Training School
ADVISORY AND PLANNING BOARDS
Meriden Regional Center
Northwest Regional Center
Lower Fairfield Regional Center
North Central Regional Center
Seaside Regional Center
New Haven Regional Center
Hartford Regional Center
Bridgeport Regional Center
Putnam Regional Center
Danbury Regional Center
Waterbury Regional Center

Figure 2

The Regional Centers

The main instrument of implementation of the Connecticut Program is to be the regional center. Whereas the state had been previously divided into two large segments which determined where a retardate would be institutionalized, it was reorganized into twelve regions for the purpose of services. The focal point of each one of these regions is such a center.

Based on the New England town government concept, the basic needs of an individual should be supplied through local (rather than central) services. Hence the primary task of a regional center is to stimulate new and to coordinate existing services for the retarded. It is based on the belief that each community has an obligation to provide for its citizens regardless of handicap. The provision of direct services to the retarded and their families, is seen as its secondary mission. In theory, a regional center could function in rented space in an office building, with its director and coordinators never giving direct assistance to retarded persons. In practice this has not worked out that way.

Realistic considerations, including financial necessities, dictated the creation of additional bed space. It was decided therefore that instead of developing a third large institution in Connecticut, an economical and reasonable alternative would be the creation of small residential facilities incorporated into the regional center design. These beds are available to the residents of each particular region and would be used strictly as -just another service to the retarded, neither more nor less important than, let us say, day care.

The task of the regional director is to supply all necessary assistance to the parent so that he will be able to maintain his child at home and thus to permit as many retardates as possible to remain in the community. The retarded persons in residence will be integrated in their daily lives with the community at large as much as possible.

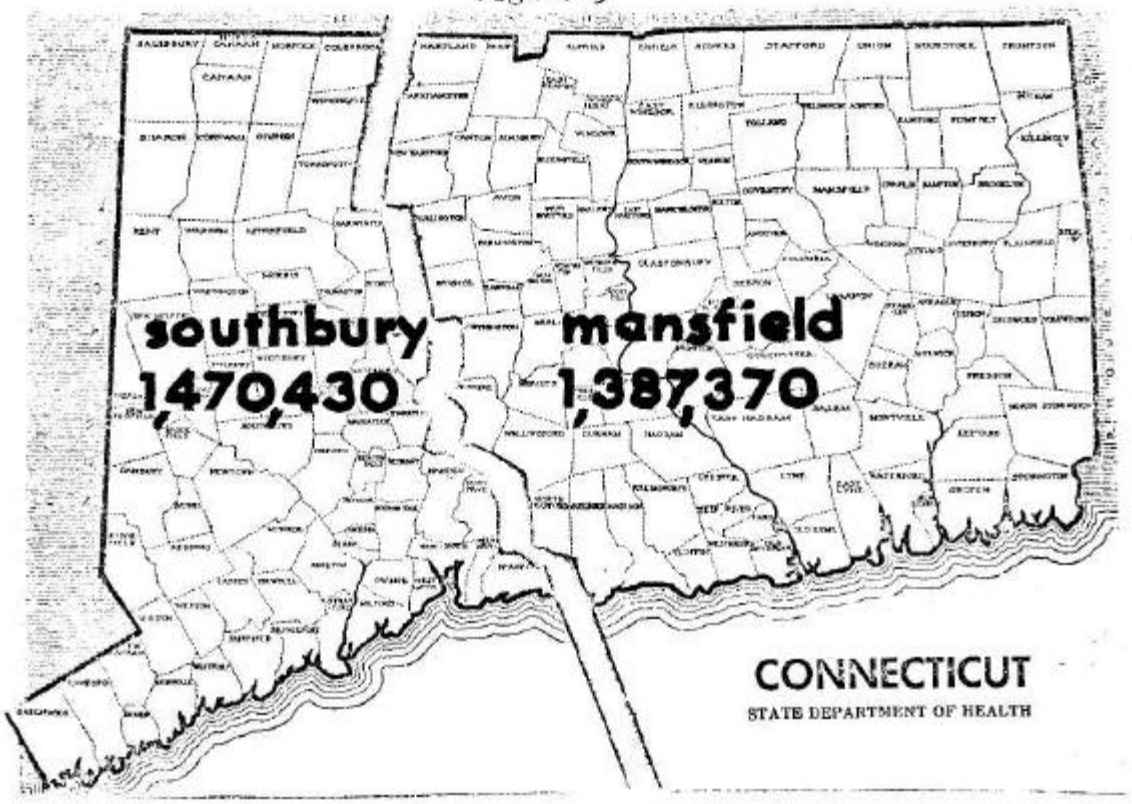
Although each of the centers differs from all the others, it is still possible to characterize their overall service philosophy through the programs they conduct. All centers are designed to maintain certain basic services, though some might offer additional ones.

Services to Retardates and their Families Living in the Community

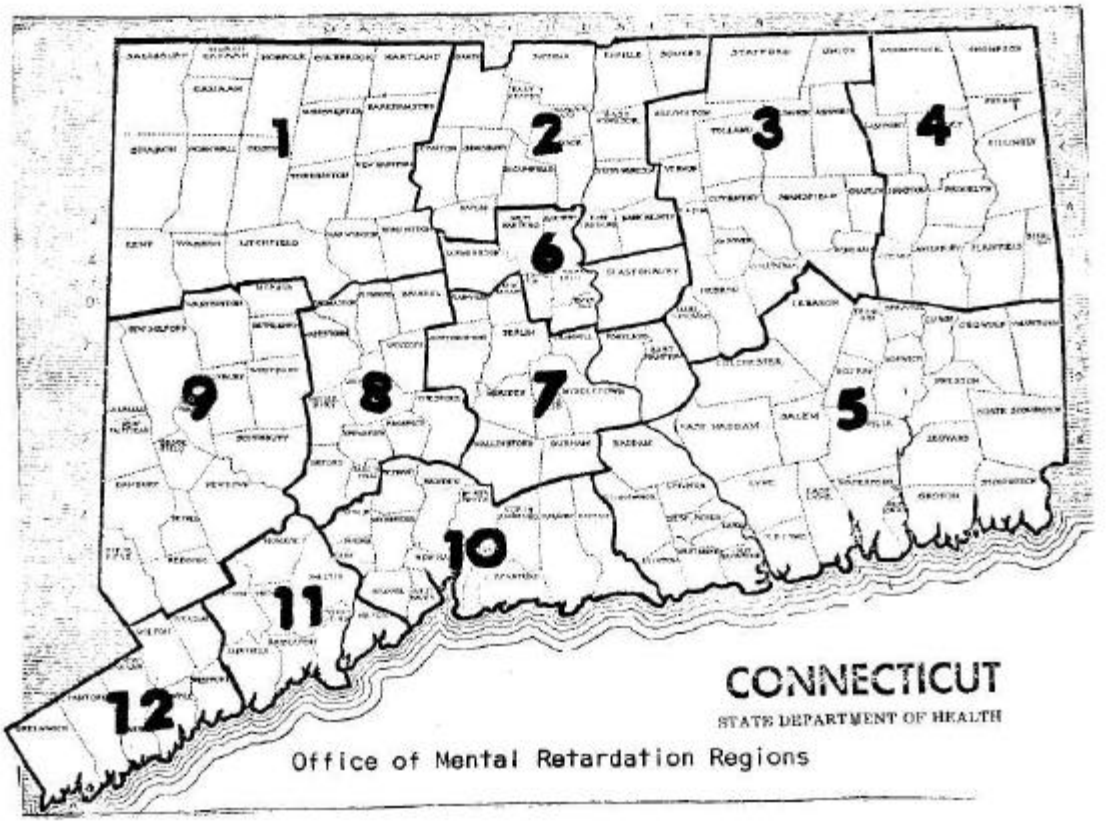
The basic services to the retarded rendered by the regional centers can be summed up as follows:

1. Day-care services for young, severely handicapped, or otherwise impaired children who are ineligible for public school special education classes. These services are rendered directly by the center, or parent groups who receive guidance from the center and financial support through the Office of Mental Retardation.

Figure 3



Connecticut as served before regionalization



Regions as assigned to regional centers

This kind of service relieves the parent of the need for continuous supervision of the retarded youngster, and has thus permitted the return of women to the (tax paying) labor force. It also helps the child in preparing him for public school. Many of these youngsters are "graduating" to the special education classes within their communities.

2. Sheltered workshops for older retardates who have reached the maximum age for school attendance and can lead a productive, though non-competitive existence. These retarded men and women are an asset rather than a burden to their communities. Sheltered workshops receive super vision and guidance from the regional center and financial aid through the Office of Mental Retardation. Frequently, one such workshop is maintained on the grounds of the center and others at other localities within the region.

The problem of programming for the adult retardate is especially important. Since medical advances have increased the lifespan of retardates to near-normal length, most persons designated as being retarded are chronological adults. No program could therefore be comprehensive without offering extensive adult services.

3. Professional services to parents, children, and agencies. Frequently, guidance and information as to the availability of services are in demand. The regional center serves as central clearing house for all activities suitable for retardates, and its knowledge is available to all.

Diagnostic services are typically not rendered directly (whenever necessary, psychological and medical evaluations are conducted), but community clinics and hospitals are utilized. Connecticut is a small enough state to permit relatively easy access to such community facilities.

4. Recreational facilities for the retarded, especially for adolescents and adults, are usually scarce, though vitally necessary. The doors of the regional center are open to all in the evening and on weekends. The mere presence of a physical locale where retardates are welcome makes a great difference. Those retardates who live nearby take frequent"advantage of this opportunity.

During the summer months, regional centers conduct special pro-grams for all retardates, including those whose programs are provided by other agencies during the rest of the year. Typically, many school-children are enrolled in this regional program.

A major task for recreation directors is the opening of general community recreational resources to the retarded. Community centers "Ys," youth organizations (Boy Scouts, Campfire Girls, etc.) have been alerted to the needs of retarded children and have responded well.

5. Educating the community is an intangible, though clearly basic necessity for the initiation of a successful regional program. The center can succeed only if retarded persons are seen by the population at large as potentially productive and intrinsically worthy individuals. Such attitudes are not established merely by lectures and talks to selected groups (PTAs, church groups, etc.), though these are also important, but primarily through demonstration in one's own agency.

The task of alerting the professional community to modern treatment philosophies in retardation is especially acute. Medical practitioners are frequently unaware of the educational and rehabilitative methods which have been developed for the retarded. Psychiatric clinics for children and adults have traditionally been uninvolved with the retarded and their families and are in need of guidance in their dealings with this population. This educational task of the center involves persistent and frequent joint case-conferences in which the professionals in the' centers involve themselves with the professionals in the community. Potentially the community possesses all the resources for working with the retarded, but many decades of neglect have brought about persisting attitudes of hopelessness, which have led to the neglect of retardates and their families. Many years of patient education efforts through daily contacts with key professionals will be needad before a meaningful change in attitude will take place.

Services to Retardates in Residence

A different concept in residential services was evidently needed. Traditionally, admission to an institution to the retarded was considered an "all or none" affair: a child's admission constituted a significant break from his previous existence. Placement was considered to be a permanent solution to whatever problems had been presented by the youngster.

A new system of admissions was designed to meet immediate needs of children and parents. Instead of the permanent Probate Commitment which had been in effect hitherto, provisions for "voluntary" or "informal" admissions were made. This procedure permits short-term residence for retardates in state facilities with the guardianship remaining vested in the parent. Parents were now able to secure residence for reasons of acute family stress (e.g., birth or death of a family member), short-term residential evaluation of a retardate (e.g., suitability for semi-independent living), or even for a family vacation. Length of such a short-term admission can be from 24 hours to 6 months.

Special care is taken that residents of a regional center do not lose their ties with the community at large. Thus, as many services as possible are secured from the community, and the desirability of return to a child's own home, foster home, or hostel is stressed.

1. Educational services to the retarded residents of the center is rendered by the town in which the center is located. School-age children designated as being "educable" or "trainable" are sent to the local schools. The program is funded through a tutition plan in which the state reimburses the **host town ±n. full.** Naturally, such an arrange ment can operate only if the number of such students is kept within reasonable bounds. The small capacity of regional centers ensures the manageable size of these groups.

If a child is excluded from school for any reason, the center maintains its own facilities and the child is served by them. This service is also open to retarded community residents who have been ex- cluded from public school for any reason.

Whenever a retarded child is excluded from a school system, the Office of Mental Retardation is notified by the State Department of Education. The Office in turn relays this information to the appropriate regional center whose task it is to investigate the case. Experience has shown that this investigation alone has reduced the number of school exclusions. If the child in question cannot be retained in school, the center will work out a plan for him which utilizes community and/or regional center resources.

2. Vocational habilitation for mildly and moderately retarded adolescents and adults is incorporated in the training department of the center. Attempts are made to place as many retardates in produc tive jobs as possible. Thus, the mildly retarded adults at the regional centers who assist in the maintenance of the institution and care of younger residents receive wages (at present, $10 a week). They are then assisted in spending their earnings judiciously.

In order to facilitate return to community living, some retardates are given the opportunity to reside in the center and to work at a job outside the center. They are then gradually encouraged to take up supervised, semi-independent residence at a carefully selected home. Those adults who are unlikely to achieve a level of functioning which would permit competitive employment are placed in sheltered workshop situations which will permit them to produce useful work according to thier ability. They, too, receive remuneration according to their ability.

3. Residential care represents the institution counterpart of parental care. In a family, however, two individuals expend consider able time and effort not only on the physical care of their offspring but also on their children's psychological and emotional development. In order to permit residents of regional centers to achieve reasonable development, they, too, must receive stimulation and support. To achieve this aim, regional centers use a variety of means: small unit size is conducive to individual interaction of aides and their charges;

hence, buildings are designed to have very small day rooms which can be attended to by one worker. Special efforts are made to bring people from the community in contact with individual residents. Federally financed programs have been particularly helpful in this area; foster grandparent programs, for example, permit the utilization of poor, elderly citizens for this kind of work.

Every effort is made to maintain contact with the child's family. Visiting hours are therefore completely open, with parents and friends being welcomed in the actual residential units.

4. Health services are not handled by a house staff, but are ob tained through clinics and hospitals in the community. Medical prac titioners are retained on a consulting basis. Typically, one physician comes regularly to the center once a week (though he is on call at all times), as does a local dentist. Whenever the need arises, medical specialists are called in. Hospitalization of a seriously ill resident occurs at the local hospital.

Such an arrangement has the dual advantage of using the best available medical personnel, while, at the same time, educating these professionals in the area of mental retardation. Many of these physicians return to their private practices with a changed outlook towards the prob-lem of institutionalization.

5. Other services which require professional consultants (speech pathology, clinical psychology, physical and occupational therapy, etc.) may be rendered directly by the house staff, or, typically, a subprofes-sional, full-time staff member would be used. He in turn would consult with a full-trained professional who is primarily affiliated with another community agency. Thus, for example, a speech teacher with a bachelor's degree may be on the full-time staff, and consult with a speech pathologist who holds a Ph.D. degree and is affiliated with a local university.

The Service List

All the identified retarded persons in the region are known to the center whether or not they need service at a given time. The purpose of this list is to permit effective lifetime planning for the individual and his family. Thus, parents are urged to use the center's resources for crisis counseling (e.g., in case of parental illness, the retarded who has lost a job, etc.). The knowledge that a given agency, a known quantity, is interested in the retarded and his parents lends a sense of security to the family.

The service list aids in forestalling the sudden emergencies which have confronted the admission committees of the traditional facilities so frequently. The followup of the entire caseload permits

methodical, lifetime help when needed, and thus strengthens the home in its ability to retain the retarded person.

The Role of the Training Schools

With the development of the regional centers the inevitable question arises as to the future role of the two larger facilities in the state system. Clearly, no one has suggested that they be relegated to a secondary position and be slighted in the newly developed regional system. Indeed, the question arises whether the regional centers are capable of performing services which are beyond the ken of the larger institutions. Theoretically, there is no community service performed by a regional center that could not be initiated by a training school. In practice, however, there are some significant inhibiting factors which mitigate against community involvement of these systems.

First, and perhaps most significant, is the inertia of systems. Whenever a large organization has been functioning for an extended period of time with clearly established goals and a philosophy of action, it is exceedingly difficult to reorient toward different ends. The philosophy of service of the large institutions typically saw residential care for the retarded as the most desirable service society can render for them. The staff took great pride in their ability to do more for the retarded than either the community or their parents were able to do. Thus, keeping a retarded child from entering an institution came to be regarded as an act of deprivation. The admission that institutionalization is in many situations an undesirable action is met by deeply ingrained, self-reinforcing psychological barriers at all staff levels.

There are still other variables which make it more difficult for traditional institutions to stimulate community action. One factor is the location of the institutions in sparsely populated rural areas of the state. Meaningful community involvement necessitates the physical location of offices and professional staff within the boundaries of population centers. The administrative tradition of state work creates an atmosphere in which employees are under the physical supervision of their superiors. Establishing semi-independent subunits of an administrative system necessitates a climate of trust and openness rarely found among training school administrators. Frequently, the climate of supervision makes such an arrangement psychologically too difficult for administrators.

Difficult as such arrangements might appear to be, they certainly are not impossible. In Connecticut the training schools have been able to develop some very effective community programs in spite of the problems involved. These programs have invariably involved utilization of new personnel consisting of persons whose professional careers were not inextricably bound to residential care. It is difficult to predict the future of the larger facilities. Probably they will have to continue

to admit for residence those retardates who present the most difficult management problems within their communities. The larger institutions have already moved toward regional programs within their own areas. They have established sheltered workshops open to day students and hostels in neighboring cities. There is little doubt that these facilities will be expanded to accomodate those persons who lack family support, but can lead reasonably productive lives in the community.

In general, half-way houses, hostels, or community residences will become more important in the care of the elderly retardate. At present, there are about 100 older retardates in Connecticut residing privately owned and state-operated homes. Whether such an activity is supervised and initiated by a large institution or a regional center staff seems irrelevant. Ultimately there need be no difference in the kind of service rendered by the various facilities.

The most important impact of the regional centers on the larger institutions has been in terms of a changed philosophy. The emphasis has moved from custody to community service. In Connecticut, there had previously been an atmosphere of friendly competition between the two large institutions. Today this competition has been extended to the regional centers, so that each facility is competing for improved residential and community services. Thus, the creation of improved and better funded residential care within the centers creates an impetus fox upgraded residential care in the large institutions.

How well Does the Connecticut Model Work in Practice--an Attempt at Evaluation

One of the most vexing aspects of socio-governmental systems is the difficulty in evaluating them. Unfortunately, we lack adequate tools to translate our behavioral constructs into a system of social, accounting, analogous to financial accounting which reveals the economic efficiency of a business system. Even worse, the concept of self-evaluation is usually an afterthought, grafted onto an existing system, and rarely built into it from its inception. Connecticut's retardation program is no exception to this rule, and to date, even rudimentary data representing population movements are unavailable to the central office; only now, at the time of this writing, and 3 years after the creation of the Office of Mental Retardation, a Director of Program Analysis has been appointed whose task it is to collect such material.

Because of the lack of availability of central data, much of what is done in mental retardation in the United States (the problem is by no means confined to this state alone) is not fully known even to the persons responsible for the administration of these programs. Research delving into the daily operations of institutions is extremely scarce (a notable and interesting exception is Thormahlen's dissertation of

training procedures in a California institution, 1965), as are inter-institutional comparisons. In order to close this gap, joint efforts between the office of Mental Retardation and the Department of Psychology of the University of Hartford have resulted in a series of investigations. Following a modest pilot study in 1964, a major project (of which this author is the director) was launched in 1965 with the aid of the Vocational Rehabilitation Administration. Included in this study were six residential facilities for the retarded, some of which were in Connecticut.

The detailed research design of the current study is not germane to this chapter, and will be made available in other forms (cf. Klaber, in press), but some of the findings are of general interest:

Institutions differ significantly in the quality of care their residents receive, even with similar per capita expenditure.

Effective institutions promote general adjustment, self-sufficiency, and intellectual development among their residents. Inef fective institutions lag in these respects.

Effective institutions are characterized by a high amount of social interactions between the retarded residents and nonretarded adults. These interactions are facilitated by the presence of volunteers, pro fessionals, and other nonattendant personnel on the wards.

Absolute unit size is more important than the overall personnel-to-resident ratio. (Thus, for example, ten units of ten residents, each with one child-care worker, is more conducive to social interactions than one hundred residents to which ten workers are assigned.)

Within a reasonable radius (100 miles), parental visits are determined by the effectiveness of the institution, and not by the dis tance to the parental home.

In-service training procedures did not have an observable effect on aide-behavior, as noted in the six institutions studied. Thormahlen also was unable to ascribe any direct relationship between training of attendants and their job performance in a California institution (Thormahlen, 1965, p. 62).

The architecture of the institution was associated with the nature and amount of programming promoting adjustment and self-suffi ciency, and played a significant role in the interpersonal contacts of residents. The more "efficient" the floor plan in terms of factory models (e.g., large rooms with glass-enclosed aide stations, rows of toilet commodes, etc.), the less likely an individual resident is to interact with a nonretarded adult.

Special programs affect ward personnel if they are conducted in the building where the residents are housed, but have no effect on their behavior if conducted elsewhere.

The foregoing examples bring to mind some immediate recommendations which might be made from applied research. The Office of Mental Retardation has kept in constant touch with our research unit and has made arrangements to upgrade residential care in accord with our findings.

The Personnel Problem

The lack of professional personnel is a national problem to which Connecticut is not immune. In theory, the regional approach brings larger numbers of professionals to the community in the service of the retarded. In practice, there has been a dearth of highly trained individuals. Except for persons in the field of special education, there are insufficient numbers of physicians, dentists, psychologists, occupational and physical therapists, nurses, social workers, aid other skilled professionals available. Even the central office lacks adequately trained personnel, and positions of consultants in medicine, social work, education, and speech services were either not made available by the State Personnel Department or remain open because of lack of qualified applicants. The situation is even more critical at the local level where regional centers lack adequate personnel to carry out their mission.

The problem is not simply one of salary, though it undoubtedly plays a role. The core of the personnel problem seems to inhere in the rigidities imposed by civil service. In a situation where an applicant's market prevails, state personnel practices simply do not meet the conditions which render such service sufficiently attractive to highly skilled personnel.

The prevailing seniority system frequently imposes relatively poorly trained department heads on young, better trained, vigorous new workers. The ensuing friction usually leads to the resignation of the junior professional. A survey of professionals who had left institutional work suggested to us that the milieu offered to the young graduate was not congruent with the expectations developed during his university training.

Problems of State Government

The framework of governmental operations imposes other difficulties on the retardation system. In Connecticut, the legislature meets only every 2 years, so that budgets have to be prepared far in advance. It happens frequently that funds become available after the needs have changed. Worse, still, is the delay in building facilities.. Long lapses often occur between the legislative approval of a facility and the time the facility commences operations. This time lapse between the conception of an idea and its execution can prove exceedingly frustrating to many persons.

To date, only three regional centers are in full operation. Several others are operative on a nonresident basis. One, Seaside, has been in operation since 1960 and thus furnishes us with the only data to evaluate the regional center's effectiveness. So far, the concept has worked well. Objective data show that Seaside's residents are developing at a more accelerated rate than those in large institutions. The waiting list is extremely small, and many residents have been returned to the community.

A breakdown of a followup of consecutive residential admissions to Seaside is illuminating. Current capacity is 240 beds. So far, there have been 443 individuals admitted. Eighty-four youngsters (19%) returned to their own home, 41 were placed in independent work situations, 15 in boarding homes, and 4 in foster homes. Fully one-third (33%) of all persons admitted have thus been returned to the community. This percentage is probably much higher than for any other public facility in this country. However, the final effectiveness of Seaside's ability to habilitate retarded persons will only be determined over the years as its long-term residential population ages. Pressures for admissions appear to have decreased, and currently a waiting list of only 15 cases is kept on the books.

The two other regional centers have not been in operation long enough (since 1966 and 1967 respectively) and their capacity is as yet so small (96 beds in each) that not much information has been accumulated. Yet, although their residential space is relatively small, each of them is serving several hundred retardates through their varied nonresidential facilities. Through these services, pressure for institituionalization of retardates appears to have diminished.

As each of the centers is assuming its individual identity, certain individual differences emerge. Thus, for example, the New Haven Regional Center has been able to create an important link with Yale University. The psycho-educational clinic under the direction of Professor Seymour B. Sarason is supplying psychological services to the center, while the center in turn has opened its administrative and care facilities to the clinic. Such mutually beneficial arrangements can be shown to be of major importance to the management of retardation as well as to the development of new directions in general social science (Sarason, et al., 1966). The Hartford Regional Center, to cite another example, is much more self-contained and has developed a program approach of its own. It has developed a program for training health aids from poverty areas in which unemployed persons are trained for work in convalescent homes and hospitals as well as in retardation facilities.

This is not to imply that the nonresidential services are without merit. Quite the contrary, substantial parent counseling, day-care, and social casework services are rendered by most regional centers almost immediately after authorization.

Whether or not the semi-autonomous development of each regional center is the most effective form of administration is as yet a moot point. Only long-term assessments will show if a more uniform, centrally imposed structure would have produced more desirable results.

In terms of daily activities, regional centers double to triple their services to nonresidents in relation to their resident population. Thus, a center with one hundred residents would typically serve an additional one or two hundred retardates living in the community. These activities supplement the already existing services and are not designed to take their place. The major populations served on a daily basis are children who were excluded from school and adults without programs in the community. Indirectly, many additional families are served through counseling, auxiliary recreation programs, etc.

The staffing patterns of the centers are somewhat flexible, but the following table of organization of the New Haven Center is fairly representative.

It is the impression of persons involved in the Connecticut program that these services are not only more humane but probably also cheaper in the long run. In the absence of cost accounting in the state facilities, this statement cannot be made with certainty, yet it se,ems reasonable to assert that even relatively expensive day services for any given individual cost only a fraction of the finances required for adequate round-the-clock care.

No discussion of a contemporary American retardation program would do justice to the subject without mentioning an all-important yet seldom alluded to factor: the ability to obtain and administer federal grants-in-aid. Many special projects serving the needs of the retarded are funded exclusively or partially by such grants. A great deal of know-how is necessary to ferret out the existence of such grants from the maze of federal bureaus, agencies, and divisions. An even greater expertise is required in the preparation of grant applications which meet the necessary requirements of the potential granting agency. Some of Connecticut's facilities have been more successful in obtaining substantial federal support than others. Consequently, a certain unevenness in the development of similar institutions is apparent. At this time, it is extremely difficult to point out the specifics as to the reasons why one administrator is more capable in developing acceptable proposals than another, yet in some ways certain agencies are much better equipped to attract and retain grant generating personnel. When this occurs, certain programs which ordinarily would be within the region of a given center will be administered by another facility.

There is little doubt that ultimately such programs will be coordinated and supervised by the Central Office. That this has not yet been done reflects the rapid growth of the program and the inevitable loose ends which are unavoidable side effects of such expansion.

NEW HAVEN REGIONAL CENTER

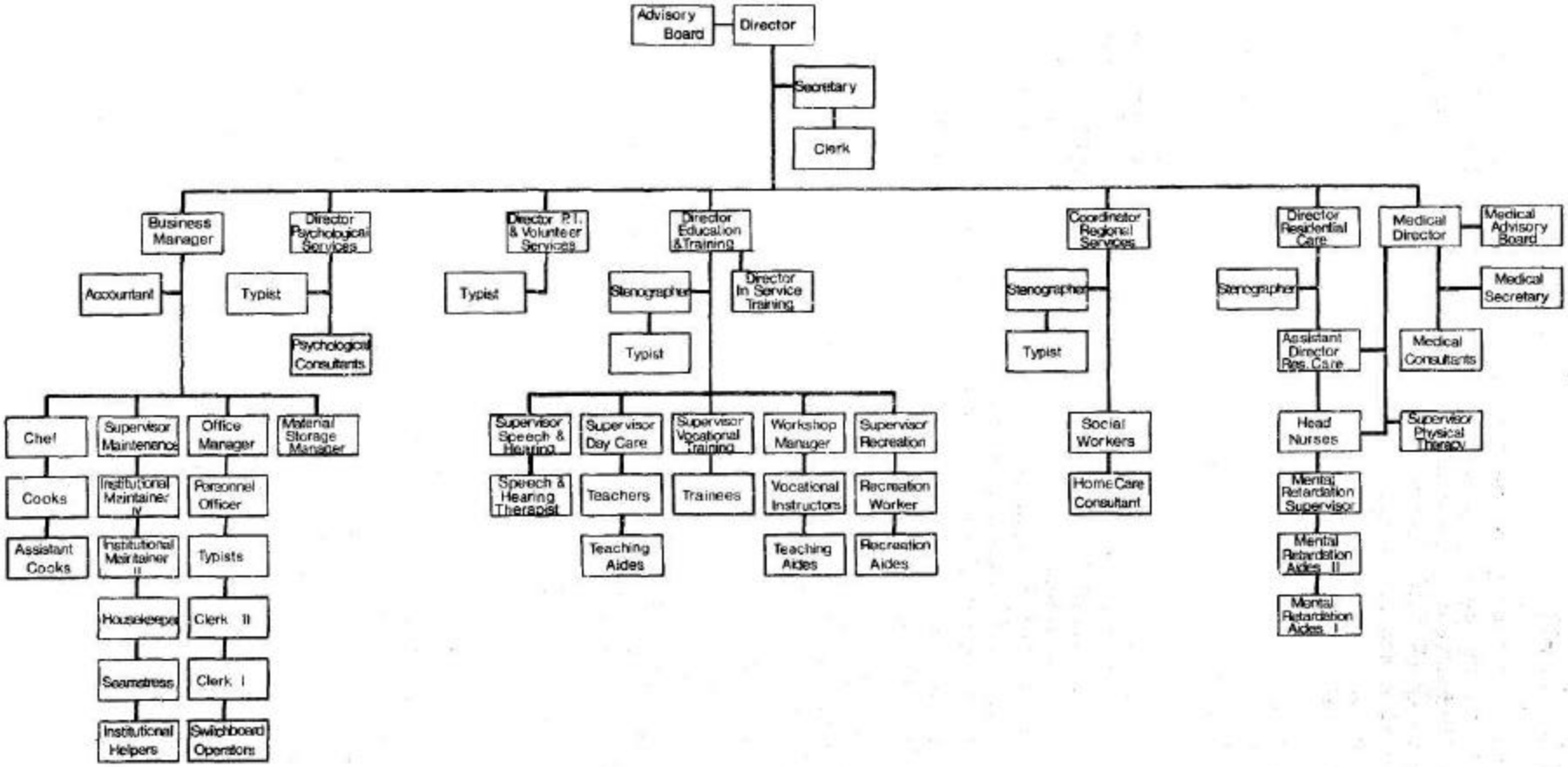


Figure 4

Planning for the Future

The Connecticut program would be ineffective indeed if it were to adhere rigidly to one mold. As new needs arise, existing facilities and personnel gain experience, new modes of thought are pursued. It would be a mistake to assume that current plans simply call for a proliferation of regional centers. Changes are constantly made. Thus, for example, the newest architectural plans call for the smallest possible "living units" rather than for larger structures.

Figure 5 represents a floor plan for a newly designed cottage for 18 mentally retarded persons. It was planned to provide maximum flexibility by making three living units, or "clusters," as self-contained as possible.

By providing separate living room space (LR) and a bathroom for each of the three bedrooms (BR), it will be possible to house three distinct groups, e.g., adults, adolescents, or young children. The cottage is currently planned to serve mild and moderately retarded persons, but could also be used for severely retarded ambulatory residents. With some modifications, profoundly retarded and physically handicapped persons could also be served by the same structure. The design builds in an appropriate ratio of personnel to residents by requiring the presence of at least one child-care worker in each cluster.

Even more advanced is the possibility of creating regional centers to serve all handicapped persons. Discussions are now under way to establish such an experimental center in which services for all the handicapped can be coordinated. Perhaps it will be possible to utilize specialized services in a more effective manner in this fashion.

Since Connecticut's state plan for the retarded, significantly entitled Miles to Go, was published (March 1966), many of its far-reaching recommendations have been carried out, yet it is already evident that a permanent planning office is essential to the continued improvement of services, and has been incorporated into the central office's table of organization.

An Overview

Services to the retarded are seen in Connecticut as belonging in a "continuum of care" which allows fluidity of movement of the individual from one type of service to another. The coordination of these services is the responsibility of the Office of Mental Retardation. This approach is implemented through a series of regional centers whose orientation is towards community rather than residential services. Side by side with the regional centers, the older, larger, residential institutions continue to serve the retarded, while state grants stimulate parent and community services.

NEW HAVEN REGIONAL CENTER
Residential Cottage

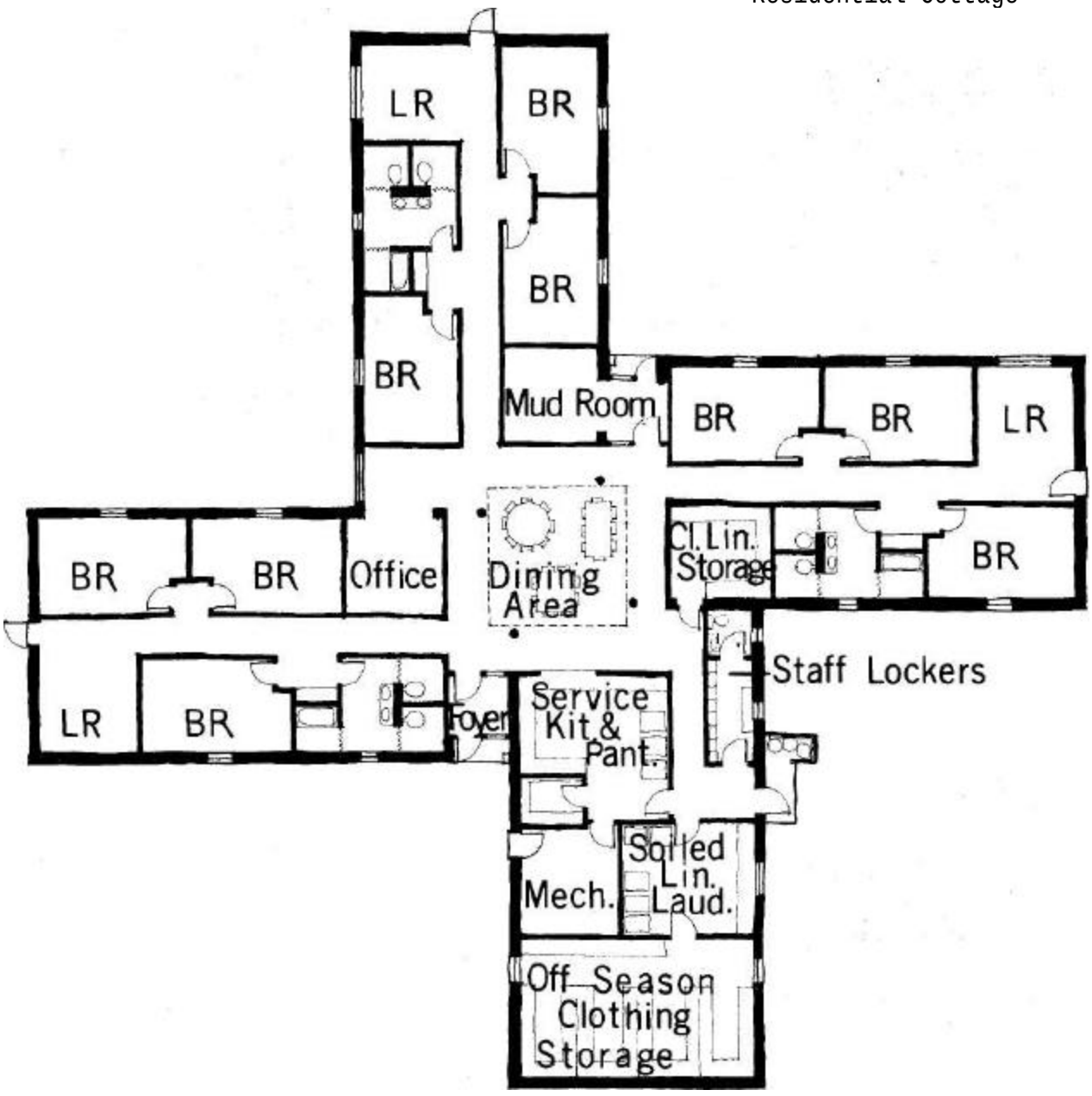


Figure 5

The entire program is based on a conviction that the needs of all the retarded from cradle to grave can best be met through the cooperation and coordinated efforts of community agencies, professionals, and others, in partnership with state programs. No longer is the state residential program a separate, isolated last or only resort. Residential care is seen as an integrated part of the complete array of services which may be beneficial to retarded children and adults during some period of their lifetime.

While it is still too early to evaluate the effectiveness of the Connecticut model, preliminary findings of studies of residential care suggest that regional centers return a much larger proportion of admissions to the community than do larger, more isolated facilities. The development of children who reside in the small centers has been shown to be more accelerated than that of children cared for in large facilities. Waiting lists have been small, and community responses most favorable.

The. Connecticut program is conceived along dynamic, ever-changing lines, so that it will be capable of responding to change. Indeed, it is hoped that the model will supersede itself when the time comes.

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APPENDIX (1963 Supplement

to the General Statutes)

Sec. 19-4c. Office of mental retardation. Deputy Commissioner. The office of mental retardation, with the advice of a council on mental retardation, shall be responsible for the planning, development and administration of a complete, comprehensive and integrated state-wide program for the mentally retarded. The office of mental retardation shall be under the supervision of a deputy commissioner on mental

retardation, who shall be appointed by the commissioner of health on recommendation of the council on mental retardation and may be removed by the commissioner after consultation with the council. The deputy commissioner shall be a person whose background, training, education and experience qualify him to administer the care, training, education, treatment and custody of mentally retarded and epileptic persons. He shall be responsible, under the general superivision of the commissioner and with the advice of the council, for planning and developing a complete, comprehensive and integrated state-wide program for the mentally retarded; for the implementation of said program; and for the coordination of the efforts of the office of mental retardation with those of other state departments and agencies, municipal governments and private agencies concerned with and providing services for the mentally retarded. He shall be responsible for the administration and operation of the state training schools, and all state-operated community and residential facilities established for the diagnosis, care and training of the retarded. He shall be responsible for establishing standards, providing technical assistance and exercising the requisite supervision of all state-supported diagnostic facilities, day-care centers, habilitation centers, sheltered workshops, boarding homes and other facilities for the mentally retarded. He shall stimulate research by public and private agencies, institutions of higher learning and hospitals, in the interest of the elimination and amelioration of retardation and care and training of the retarded. He shall be responsible for the development of criteria as to the elibility of any retarded person for residential care in any public or state-support private institution and, after considering the recommendation of a properly designated diagnostic agency, may assign such parson to a public or state-supported private institution. He may transfer such persons from one institution to another when necessary and desirable for their welfare. (1959, P. A. 148, S.22.) (See Ch. 305, part III.) (Repealed P.A. 377, Sec. 3., June 1963.)

Sec. 17-175a. Voluntary admission to facility for mentally retarded persons. Termination of admission. Any person who has been a resident of Connecticut for the two-year period immediately preceding an application made by him or on his behalf under the provisions of this section and section 17-175b, and who is, or appears to be, or believes himself to be, mentally retarded or epileptic but not mentally ill, may apply, in writing, to the deputy commissioner on mental retardation, on a form prescribed by said deputy commissioner, for admission to any state school, diagnostic center or other institution having facilities for mentally retarded or epileptic persons. Such application shall be accompanied by a certificate, signed by a physician licensed to practice medicine in the state, that such person is suitable for admission to such school, center or institution, and by a psychological diagnostic evaluation provided by a psychologist certified under the provisions of chapter 383 when such applicant has the physical and mental capacity for such evaluation. The application for such person,

if such person is a minor, may be made by a parent, guardian of the person of, or person having custody of, such minor or, if such person is an adult incompetent, may be made by the conservator or person having custody of such incompetent. The deputy commissioner shall approve any such application for admission if the person on whose behalf application is made is suitable for admission to such school, center or institution and facilities to accommodate him are available and may terminate such admission at any time when he feels such person will not profit from a further stay. (1961, P.A. 260, S. 1; 1963, P.A. 377, S. 1.)