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EXTENDING CLINICAL SERVICES FOR MENTALLY RETARDED CHILDREN AT THE COMMUNITY LEVEL.

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A CLINIC TEAM CONSISTING OF A PEDIATRICIAN, SOCIAL WORKER, PSYCHOLOGIST, AND PUBLIC HEALTH NURSE PROVIDED EVALUATIVE SERVICES. THE PURPOSES WERE TO DEMONSTRATE A MULTIDISCIPLINARY APPROACH TO DIAGNOSIS AND PARENT COUNSELING, TO TRAIN AND STIMULATE INTEREST OF OTHER PROFESSIONS IN MENTAL RETARDATION, AND TO HELP COMMUNITIES DEVELOP THEIR OWN SERVICE FOR THE RETARDED CHILD AND HIS FAMILY. FROM MAY 1960 TO OCTOBER 1961 THE DEMONSTRATION PROJECT HELD A TOTAL OF 14 CLINICS IN WHICH 54 CHILDREN (FOUR AT EACH CLINIC) WERE EVALUATED. THIS STAFF ALSO CONDUCTED AN INSERVICE EDUCATIONAL PROGRAM FOR PUBLIC HEALTH NURSES AND SOCIAL WORKERS. OTHER PROFESSIONAL PERSONNEL ATTENDED CASE STAFFINGS, INCLUDING PHYSICIANS, TEACHERS AND SCHOOL ADMINISTRATORS, AND PSYCHOLOGISTS. FOLLOWING TERMINATION OF THE DEMONSTRATION PROJECT, A CLINIC TEAM WAS ORGANIZED THROUGH THE EFFORTS OF SEVERAL PUBLIC AGENCIES, INCLUDING THE PUBLIC SCHOOLS. A SPECIAL EDUCATION CLINIC UNDER THE AUSPICES OF THE PUBLIC SCHOOLS DEVELOPED. OTHER BENEFITS ASCRIBED TO THE PROGRAM AS WELL AS PROBLEMS IN ITS IMPLEMENTATION ARE POINTED OUT AND BRIEFLY DISCUSSED. TABLES INCLUDE DATA FOR THE 54 CASES. (VO)

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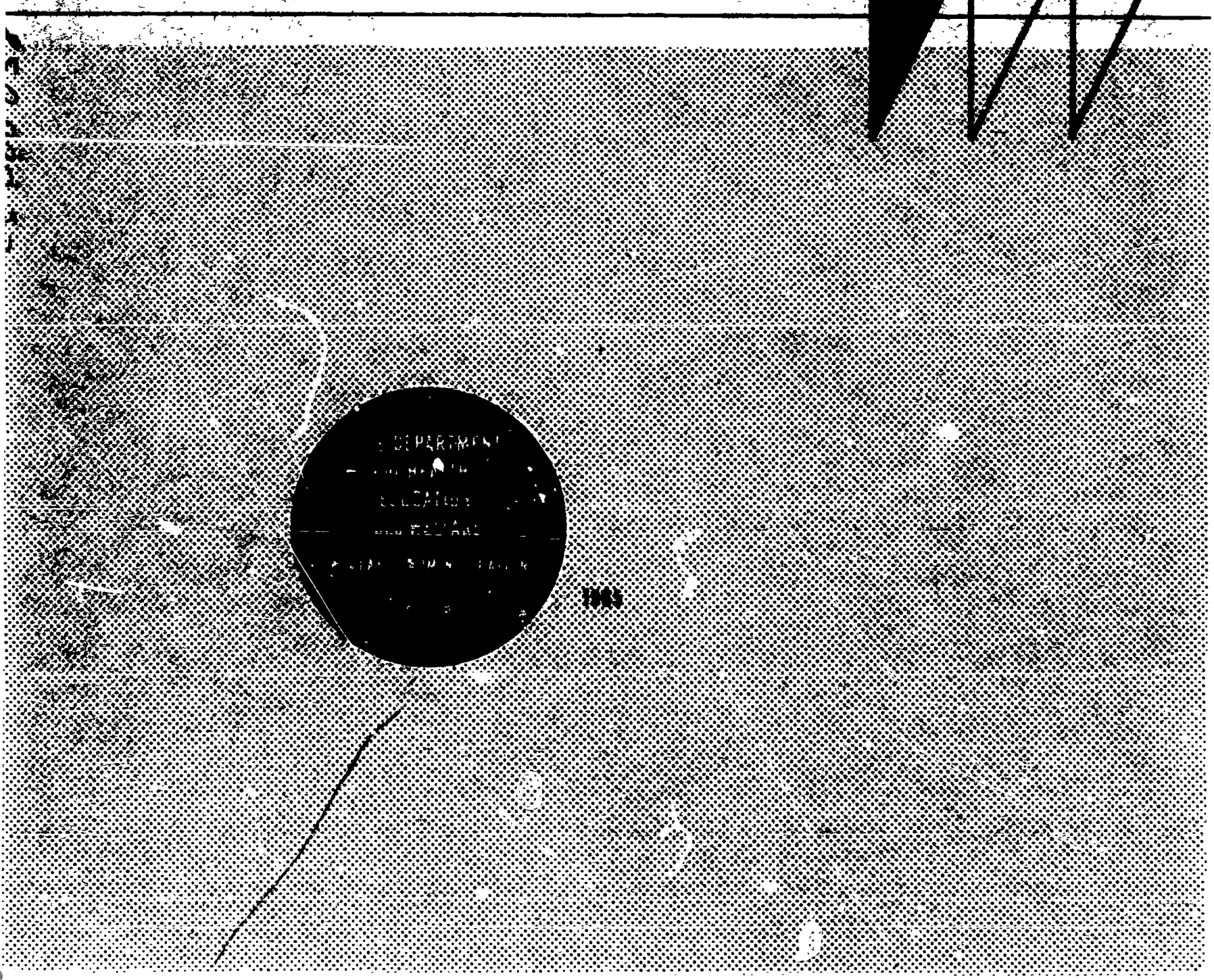

FOREWORD

Despite an increasing number of programs for providing clinical services to mentally retarded children and their families, demand far outstrips availability. To meet this need, new ways of extending services are being initiated by some of the existing clinics. One of the most successful has been the Traveling Clinic Demonstration Project undertaken by the Child Development Clinic of Childrens Hospital in Los Angeles.

In 1962 the Children's Bureau published a report on this project, prepared by the clinic team, under the title, "A Demonstration Project Utilizing Child Development as the Focus for Community Interaction with a Local Health Department." This report, which was principally concerned with the demonstration in Pasadena, California, included a section on "Evaluation of the Clinic Demonstration" assessing the community's experience as of the end of 1961.

The continued interest in the publication has exhausted the supply, and it is now being republished under the new title, "Extending Clinical Services for Mentally Retarded Children at the Community Level." The section written previously on the evaluation of the project has been retained, but a new section prepared by Sylvia Schild, A.C.S.W., reports on and evaluates the project a of 1964.

This publication should be useful to communities because it describes a successful service and, what is more important, presents a creative approach to the search for ways to provide needed services to mentally retarded children and their families.

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EXTENDING CLINICAL SERVICES FOR MENTALLY RETARDED CHILDREN AT THE COMMUNITY LEVEL

by

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and

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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EXTENDING CLINICAL SERVICES for MENTALLY RETARDED CHILDREN at the COMMUNITY LEVEL

INTRODUCTION

Mental retardation, a problem area of bewildering complexities, has in recent times come to the forefront of public attention and concern. On the national, State, and local levels, responsible agencies have been stimulated to reexamine the existing patterns of services and to initiate planning for adequate community programs to serve the needs of the mentally retarded and their families.

Communities facing the challenge have found that it is not always economical, or feasible, to develop services for the retarded within the existing structure of community organization. Mental retardation, being a symptom of many problems (organic and functional), requires services from a multi-faceted program. The individual afflicted with retardation has many special needs and requires services from many sources. Yet these services, to be truly effective, must be provided in an integrated, cohesively planned for, meaningfully connected way in order to be optimally beneficial. Communities, on the other hand, have other demands and responsibilities to fulfill which have dictated the organization of their services. Historical events, economics, geography, demographic facts, etc., have all helped to shape the development of community services. Change is hard to come by and solutions to the dilemma difficult to achieve.

There is no single answer to the problem of coordinated community organization of services to the retarded. Nor need there be. Many approaches and creative efforts will result in partial, or perhaps final, solutions in various localities. Fortunately, since 1954, under the aegis of the U.S. Children's Bureau, pilot projects have been experimenting with new approaches to meet the challenge. One of these has been the Child Development Project at Childrens Hospital of Los Angeles, whose Traveling Clinic Demonstration has proven to be one efficacious method of helping communities to develop a needed service for young

mentally retarded children and their families by utilizing existing resources within the existing structure of local community organization. Since 1959, 10 community child development diagnostic and counseling clinics have been established in different localities in Southern California.

The following description of the demonstration year in one of these communities, Pasadena, and the followup assessment will illustrate the traveling clinic approach. Though different problems will be encountered in different geographic areas, this demonstration should be helpful to other communities seeking new ways to develop programs for the mentally retarded or for groups with other problems.

THE TRAVELING CLINIC PROJECT

In the fall of 1959, a traveling clinic service to Southern California counties was initiated through the Child Development Project at Childrens Hospital of Los Angeles and the California Bureau of Maternal and Child Health.* The traveling clinic demonstration had a three-fold purpose: To demonstrate the multidisciplinary approach to the diagnostic evaluation of the mentally retarded child and parent counseling; to train and stimulate interest of other professionals in the problem of mental retardation; and to help communities develop their own service for the mentally retarded child and his family.

The traveling clinic service was designed to operate in public health settings, because mental retardation is a chronic handicapping condition posing important health problems. Approximately 3 percent of the population of the United States is mentally retarded. This means that 1 in 12 persons are closely affected. Thus every community has the problem of caring for its more limited members.

The clinic team from Childrens Hospital visited the community desiring the demonstration at the invitation of the local health department. As sponsors of the program, the health department assumed administrative responsibility. The clinic team consisted of a pediatrician, social worker, public health nurse, and psychologist from the Child Development Project at the Los Angeles Childrens Hospital. The services consisted of a diagnostic evaluation of the child and counseling for the parents. In addition, the demonstration team provided inservice training

* This project was supported by the Children's Bureau, Welfare Administration, U. S. Department of Health, Education, and Welfare, through the Bureau of Maternal and Child Health, California State Department of Health, with the cooperation of Childrens Hospital, and the Department of Pediatrics of the University of Southern California School of Medicine.

to local professionals, both in structured sessions and in the demonstration of skills and techniques at the clinic staffings in which the community representatives participated. The followup care and recommendations were planned by the total group (demonstration team and community participants) so that the family could be provided with the services available in the local community. The local professional people and agencies were encouraged to assist the family in maintaining the child in his own home and community whenever feasible.

THE PASADENA DEMONSTRATION

The Pasadena traveling child development clinic was the second demonstration undertaken by the Child Development Project team. Pasadena is an incorporated city of 22 square miles, in Los Angeles County. It is within a 10-mile distance from Los Angeles, and is also a part of the San Gabriel Valley. The population for 1959 was estimated at 123,000. The city has an average birth rate which is lower than the average rate in Los Angeles County and in the State of California. This birth rate reflects the fact that in this city, older persons constitute a much higher proportion of the population than they do in the State as a whole. However, in recent years, there has been a shift in population, with many younger families moving to areas which, because of slum clearance, are being converted into middle-class multiple housing units.

The decision to establish a field clinic in Pasadena was made in January 1960 at the request of the health officer. There were several factors governing this decision. Pasadena, because of its proximity to Los Angeles, provided a good situation to test out the value of the traveling clinic in a community which had access to reasonably adequate local resources. Considerable interest in the clinic had been expressed by personnel in the city school system which, through its division on special education, operates a fine program for the educable retarded child. The health department was enthusiastic about sponsoring the project. The health officer had obtained approval for the project from the Welfare Planning Council of Pasadena.

EARLY PLANNING AND ORGANIZATION

Since it was the second venture of the team, the Pasadena clinic benefited from the experiences of the earlier demonstration in Orange County, but certain factors, peculiar to Pasadena, presented new challenges and problems.

Almost immediately a problem developed because of insufficient communication between the Welfare Planning Council and the local pediatric

society. The initiation of services was delayed because some objection to the demonstration was expressed by a few of the pediatricians. A joint conference between the project director and senior consultant and the Pasadena Pediatric Society was held to clarify the situation. The initial opinion of the society was mixed, and complete support was not obtained. During the course of the demonstration, however, referrals to the clinic were made by several pediatricians and subsequently no further objection to the program was evident.

The health officer for Pasadena delegated responsibility for the project to the director of public health nursing. The health department screened referrals to the clinic, arranged for scheduling, obtained reports pertinent to the case situation, selected a clinic setting, handled routine laboratory work for the patients (routine hemoglobin, urinalysis, urine phenylpyruvic test and tuberculin test), and provided public health nursing service for evaluation home visiting and followup nursing care. Several planning meetings were held between health department personnel and clinic team members to delineate policy and procedure.

A series of six sessions on mental retardation was held by the team for the benefit of the local public health nurses, school psychologists, teachers in special education, and director of the training school sponsored by the parents. The training program was well received and was presented to a group of 20 to 25 people at each session.

The first facility to be used as the clinic setting was the Civitan Training School for the Mentally Retarded, operated by the San Gabriel Valley Association for Retarded Children. The building had just been purchased for the Association by the Civitan Organization as one of their projects in behalf of mentally retarded children. However, due to the increasing size of the clinic attendance and to the enrollment in the school itself, it soon became necessary to find larger, more adequate quarters. In December 1960, the clinic moved to the Roosevelt School, a Pasadena city school facility for physically and mentally handicapped children. As a result of this move, the interest of the parent group waned, although the training school director continued to make referrals and always cooperated in accepting those recommended for participation in the parent group training class.

The interest and services of a private pediatrician were obtained early in the planning, and she participated regularly throughout the demonstration. The cooperation of the Pasadena Welfare Bureau was also obtained, and one of their staff participated in clinic staffings from the inception of the clinic. From the start, school personnel (including administrators, health personnel, teachers, and psychologists) participated in the clinic staffings, particularly those related to cases they had referred for evaluation.

The support and guidance of the California State Department of Health consultants in maternal and child health, public health social work, and nursing were given generously and aided the team throughout the demonstration period.

A policy was established of accepting patients from adjacent communities in the San Gabriel Valley. One reason for this was that Pasadena services are often given to these residents, since certain communities, such as Altadena and Monrovia, are more closely identified with the Pasadena area than with Los Angeles City. Since these communities are officially served by the Los Angeles County Health Department, its cooperation and participation were also solicited and obtained. In the beginning, the Los Angeles County Health Department agreed to accept only two cases per clinic for followup nursing service. Later on, home visit evaluations by the public health nurses and more participation by county public health social workers were received. This collaborative relationship which was established with the Los Angeles County Health Department was significant in the development of an ongoing Pasadena Child Development Clinic after the demonstration period was concluded.

CLINIC OPERATION

The first clinic was held in May 1960, followed by a second in June. After a brief recess, due to summer vacations, the clinic was resumed and was conducted on a regular monthly basis from October 1960 through October 1961. A total of 14 clinics was held in which 54 children (4 per session) were evaluated. All children were evaluated pediatrically and were seen for psychological and social work assessments. Public health nursing home visits were made prior to clinic in 48 cases; 6 children resided in Los Angeles County at a time when public health nursing evaluations were not yet available to the clinic.

Referrals to the Pasadena Health Department were made by the sources shown in table I.

TABLE I

Sources of Referral of 54 Cases Seen in the Pasadena Child Development Clinic

Area:	Pasadena.....	33
	Los Angeles County.....	21
	Total.....	54
By:	Public Health Nurses.....	8
	Well Child Conferences.....	8
	Private Physicians.....	15
	Schools.....	10
	Association for Retarded Children...	10
	Pasadena Dispensary.....	2
	Pasadena Welfare Bureau.....	1
	Total.....	54

The first cases referred to the clinic reflected problems which were arousing considerable community concern. The occurrence of associated physical handicaps and diseases was consistently high (tables II and III) and complicated the problems of these children whose diagnoses are listed in table IV.

TABLE II

Associated Physical Handicaps

Ophthalmologic disorders		24
Esotropia	7	
Myopia	6	
Nystagmus	4	
Blindness	2	
Glaucoma	1	
Optic atrophy	1	
Structural defect	1	
Bilateral cataracts	1	
Choroidal defect	1	
Speech defects		6
Congenital heart disease -- type undetermined		4
Undescended testicles		4
Hard of hearing defects		2
Growth retardation		2
Hemi-hypertrophy		2
Epiphyseal dysplasia		1
Ectodermal dysplasia		1
Vertebral defects		1
Deafness		1
Cranial nerve III paresis		1
Total		49

TABLE III

Associated Diseases

Convulsive disorder.....	7
Dental caries.....	5
Tonsils and adenoids.....	2
Poor nutrition.....	2
Eczema.....	1
Iron deficiency anemia.....	1
Respiratory infection.....	1
Ringworm.....	1
Alopecia.....	1
Inguinal hernia.....	1
Total....	22

It is interesting that 14 children were diagnosed as pseudo-retarded and 1 as completely normal. This means that in the total number of cases seen (54), approximately 27.8 percent of the children were found to have normal intelligence. This figure may reflect inadequate screening of emotionally disturbed children, or it may be due to the small sample size. Usually 20 percent of the children referred to the Child Development Project at Childrens Hospital have normal intelligence; it may be significant that more than one-fourth of the children referred to the Pasadena clinic as possibly mentally retarded had normal intelligence.

TABLE IV

Specific Diagnoses Made in 54 Children

AAMD Code Number*		Number
12.4	Encephalopathy due to postnatal infection with convulsive disorder.....	1
33	Encephalopathy due to anoxemia at birth.....	3
34.2	Encephalopathy due to postnatal injury; hematoma.....	1
42	Phenylketonuria.....	1
49	Encephalopathy, other, due to metabolic, growth or nutritional disorder.....	1
61	Cerebral defect, congenital.....	10
64	Mongolism.....	10
72.x	Encephalopathy associated with cerebellar degeneration.....	1
78	Encephalopathy associated with prematurity...	2
79	Encephalopathy due to unknown or uncertain cause with structural reactions manifest...	4
79.46	Encephalopathy due to unknown or uncertain cause with convulsive disorder.....	1
81	Cultural-familial mental retardation.....	1

* Nomenclature devised by the American Association for Mental Deficiency, 1960

TABLE IV

Specific Diagnoses Made in 54 Children
(Continued)

AAMD Code Number*		Number
82	Psychogenic mental retardation associated with environmental deprivation.....	3
83	Psychogenic mental retardation associated with emotional disturbance.....	9
84	Mental retardation associated with psychotic (or major personality) disorder.....	2
89	Mental retardation, other, due to uncertain cause with the functional reaction alone manifest.....	2
89.4x	Mental retardation, other, due to uncertain cause with convulsive disorder.....	1
	Normal.....	1
	Total.....	54

* Nomenclature devised by the American Association for Mental Deficiency, 1960

In addition to the counseling and guidance offered to the parents in the clinic interviews, recommendations were made for followup care. These are listed in table V.

TABLE V

Recommendations for Followup Care in 54 Children Seen in the Pasadena Child Development Clinic

Public health nursing service.....	19
Additional medical service.....	15
Social casework.....	20
School services.....	13
State hospital services.....	3
Speech therapy.....	1
Parent group referrals (including training school classes).....	11
Psychiatric clinic.....	3
Return evaluations.....	6

The Pasadena traveling clinic was unusual in terms of community participation and interest in the demonstration, as shown in table VI.

TABLE VI

Additional Community Personnel Attending Clinic Staffings

Pasadena Health Department		11
Health Officer	1	
Director of Nurses	1	
Public Health Nurses	9	
Social Workers		13
Pasadena Welfare Bureau	4	
Pasadena Medical Aids	1	
Pasadena Dispensary	1	
Pacific State Hospital	2	
Los Angeles County Bureau of Public Assistance	2	
Los Angeles County Bureau of Adoptions	3	
Private Physicians		3
Los Angeles County Health Department		20
Public Health Nurses	14	
Public Health Social Workers	5	
Mental Health Consultant	1	
Pasadena City Schools		61
Physicians	2	
Audiometrist	1	
Coordinator of Guidance	1	
Supervisor -- Special Education	1	
Occupational Therapist	1	
Psychologists	6	
Principals	9	
Nurses	11	
Superintendents	3	
Teachers	25	
Welfare and Attendance	1	
Los Angeles County School System		2
Health Consultant	1	
Special Education Consultant	1	

TABLE VI

Additional Community Personnel Attending Clinic Staffings
(Continued)

Other Pasadena Agencies		4
Child Care Center	1	
Speech Clinic	2	
Parent Association for Retarded Children	1	
State of California Department		7
Public Health	5	
Social Welfare	1	
Education	1	
Students		7
Psychology Interns	2	
Administration Intern	1	
USC -- Speech	2	
Los Angeles State College -- Special Education	2	
Other Visitors		9
Physician -- New Zealand	1	
Pepperdine College	1	
Children's Bureau -- Welfare Administration, U.S. Department of Health, Education, and Welfare	3	
Child Welfare League of America	1	
Pacific Oaks Friends School	2	
Childrens Hospital Resident Physician	1	
Total		137

Others came for various staffings; the total number of those in attendance at the 14 clinics (not including the clinic team) was 255. This large attendance reflects the increased interest by Pasadena's professional community in the demonstration project and in the field of mental retardation.

INSERVICE EDUCATION

The dynamic experience of the concrete case staffings contributed to the success of the traveling clinic demonstration. The large numbers who attended the clinic sessions had the benefit of learning how difficult problems were coped with and how resolutions were made through the technique of working as a team.

In addition to the formal series of six lectures given by the team prior to beginning the clinic operations, further inservice training was provided for the public health nurses and social workers in Pasadena. Five additional hours were given to nurses of the health department within their program for inservice education. The content was on mental retardation as a public health problem, home training techniques, the emotional aspects of the problem (presented by the team social worker), a review of the cases seen with emphasis on the nursing problems, and the galactosemic and phenylketonuric diets.

Members of the staff of the Pasadena Visiting Nurse Association attended the inservice education program offered to the social workers in the community. Later, the visiting nurse staff provided a session on mental retardation and used the film, "The Public Health Nurse and the Mentally Retarded Child."

A six-session program was arranged with the cooperation of the director of the Pasadena Welfare Bureau for social work agencies in Pasadena. The first four sessions, covering medical, psychological, and public health nursing aspects of mental retardation, were given by the project staff. The last two sessions were given by the social worker, with emphasis on the casework aspects of dealing with families of mentally retarded children. About 18 social workers attended each session, representing the following agencies: American Red Cross, Bureau of Public Assistance, Catholic Welfare Bureau, Los Angeles County Medical Aids - Pasadena District, Pasadena Day Nursery, Pasadena Welfare Bureau, and Visiting Nurses Association.

Also, in an effort to help public health nurses become better acquainted with the social worker's role and to discriminate between the contributions of the social worker and the public health nurse, a concrete demonstration of the social worker interview was arranged. The public health nurse observed the interview with the family she had visited. Following the interview, there was an opportunity for the nurse to discuss with the team social worker the interview process, the

focus and goals of the interview, and how the social worker formulated her social diagnosis. There was discussion by the team public health nurse on the contribution of the home visit, and the public health nurse's assessment of health needs and the family situation. While there were some threatening elements in this situation, the nurses on the whole responded favorably. To the team social worker, it seemed as if each discipline acquired a deeper appreciation for the other's contribution to the evaluation of the child by team effort.

TERMINATION OF THE DEMONSTRATION

Benefiting from the experience of the earlier demonstration, several steps were taken to prepare the way for eventual withdrawal from Pasadena. First of all, recognizing that the clinic had had a shaky start with only minimal cooperation from the local pediatric society, it was agreed that the health department would need more than the usual one year to help organize the community to provide continued service. Many meetings for ongoing evaluation and planning for eventual withdrawal were held all through the year, involving personnel from the health department, the school system, and the welfare department. The termination date was established for October 1961, in order to allow time for further training of potential team members. Because of the complexities in organizing community resources in Pasadena and the area of Los Angeles County served by the clinic, the identities of those who would carry on the professional functions of the clinic were not known until March 1961. The last demonstration clinic was held in October 1961. At that time there were 10 cases yet on the waiting list for services in the clinic.

Through the combined efforts of the health departments of Pasadena and Los Angeles County, the Pasadena school system, and the Pasadena Welfare Bureau, a clinic team was planned for continued child development clinic services in Pasadena. The health department in Pasadena has continued to be administratively responsible for the clinic. It also provides public health nursing services for clinic cases from the city health jurisdiction. The Pasadena school system has released time to a school psychologist and a school physician for participation in the clinic. A private pediatrician who practices in Los Angeles County and who has been with the demonstration clinic from the beginning is providing medical supervision. Social work and public health nursing services of the county health department are available to county patients served in the clinic. The Roosevelt School for Physically Handicapped Children (part of the public school system of Pasadena) has continued to offer its facility for the clinic conferences. The Pasadena Welfare Bureau, which had had a social worker continuously assigned to the demonstration clinic, continues to offer services for Pasadena residents. This joint effort between the two overlapping health jurisdictions is an admirable example of team work in action!

As a result of early plans for ending the participation of the Child Development Project staff in the local clinic, it was possible to give the people assigned to the clinic responsibility for working up cases under the supervision of the project staff. The public health nurses presented their home visit evaluations and the Pasadena social worker contributed the social evaluations at clinic staffings. The psychologist and pediatrician were trained in Gesell developmental testing. All were given the opportunity to counsel parents in the group setting. This supervised inservice training was designed to bolster the confidence of the local professional team members in assuming their roles in their own community clinic.

A local private philanthrophic group, the Pasadena Child Health Foundation, donated $1,200 which was used to provide the ongoing Pasadena clinic with speech consultation. The Speech and Hearing Department of Childrens Hospital was helpful in providing the consultants.

Eventually, it is hoped that the Community Planning Council in Pasadena will include in its coordination of community health services for children those given by the Pasadena Child Development Clinic.

EVALUATION OF THE CLINIC DEMONSTRATION, DECEMBER 1961

It is difficult to make a precise evaluation of this kind of clinic demonstration. The best proof of success would be the availability of lasting services in diagnosis and counseling for the mentally retarded child and his family directly in his own community. How the Child Development Clinic in Pasadena will develop depends on many factors which will not become clear for some time. Ideally, the clinic services should ultimately be incorporated within the structure of medical services in the community.

However, in spite of the brief period of time since the termination of the demonstration, some beneficial effects have been noted. Suggestions for changes in school planning have come from members of the departments of school health, special education and guidance who participated so actively in the clinic demonstration. These professionals drew out of the experience the conviction that the clinic had value as a preventive measure in the early identification of school problems, thus enabling them to initiate planning which would ameliorate the difficulties encountered when the child reaches the school situation. As a result of their experience in the demonstration, the guidance and counseling department in the Pasadena schools have requested, in their new budget, a position for one school social worker. In addition, a plan submitted to the board of education for the establishment of a demonstration clinic with the team approach, for diagnosis of all children presenting problems in the school situation, has been approved. This program will include normal children as well as those requiring special education.

Again, as a result of the participation of the speech consultant, the special education department has decided to donate the time of a speech therapist to the clinic. The school system social worker will be able to offer some service in case there are gaps in this area. It is planned to have the school speech therapists and psychologists rotate through the clinic in order to give them inservice training and experience in the field of mental retardation. Most significant, a class for trainable mentally retarded children has been set up by the board of education this year.

The health department was generally appreciative in evaluating the demonstration project (in response to the Child Development Project questionnaire). As a result of this demonstration of the team approach, the social workers in the welfare bureau and the public health nurses in the health department are collaborating more closely in the maternity and child health programs than they had in the past.

More frequent consultation service from other agencies is being sought on the problems of the children being served by the health department. There has been an increase in the number of requests to the health department for help with special developmental problems in children. This seems to be due to a greater awareness on the part of the public health nurse and physician in the well child conference of special developmental problems and needs.

Further education in mental retardation is being included in the inservice training program for public health nurses. The staff or the welfare bureau and the public health nurses of the health department are continuing to meet, jointly, in mental health conferences with the mental health consultant of the health department. As a result of experiences in the demonstration clinic, the well child conference and prenatal clinic procedures and followup nursing service are being reviewed.

The health department sees their role in regard to mental retardation to be that of continuing to provide skilled supervision and consultation to the families, furthering the development of an adequate public educational program for trainable children in Pasadena to meet the need which exists for this service, and stimulating the community to develop learning opportunities for professional persons so they can become more proficient in the recognition and management of the problems of retardation.

Briefly, in summary, it would seem apparent that the demonstration clinic has already had an important impact on the health department, welfare bureau, and school departments of counseling, special education, and health. There seems to be ready acceptance of the multidiscipline team approach not only to the problems of the child with mental retardation but to any child with a problem in the school situation or receiving services in the health department. The philosophy of considering the total child and the total family situation as well as the specific pathology in order to find solutions to the problem is reflected in the planning for new services and review of established ones. It has

also been demonstrated that better use of existing resources is being made in the community to provide service to the mentally retarded child and his family.

FOLLOWUP ASSESSMENT, DECEMBER 1964

The Pasadena Child Development Clinic has continued to serve its community, constantly making visible the existing demand and need for this kind of service in the local community. The clinic has met regularly on a monthly basis and has had to deal with new problems of independent functioning. The demonstration team members were frequently called upon for additional consultation; however, this dependency has been diminishing as the Pasadena clinic team have resolved their internal difficulties and gained confidence through their own experiences.

The clinic has continued to see four children at each monthly staffing and has also assumed additional responsibility for followup reevaluations, as recommended. This latter responsibility has served to strengthen their learning and their professional commitment to the patients seen in the clinic. The health department has continued to exercise the administrative role. The local agencies, initially committed to cooperative service, have maintained their support and participation.

The clinic moved after the year of demonstration to an outpatient medical dispensary in the community, because of two problems arising for the parents in the school setting. Parents were often upset at the sight of some of the extremely handicapped children attending the Roosevelt School. Many parents also found a medical diagnosis hard to accept, coming as it did from a school setting; the diagnostic clinic was identified primarily with the educational setting and the medical diagnosis was thus overshadowed. For these reasons, the clinic staff decided that it was necessary to place the clinic physically in a medical setting. As of December 1964, the clinic was moved for administrative reasons to its own separate facility provided by the health department. The administrative structure was redefined to retain the benefits of medical identification; the administrative direction of the clinic was delegated to the team pediatrician. This move strengthened the image of the clinic as a medical service in the community and properly placed responsibility for those children requiring medical supervision.

Furthermore, this administrative change reflected the resolution of some internal conflicts engendered within the team by lack of clarity as to their roles in the multidisciplinary process. During the demonstration period, the community participants became so engrossed in learning about the problems of mental retardation that little attention was given to the roles of the region's disciplines. The demonstration team, having already learned to live with each other's idiosyncrasies, to share contributions, to compromise, to be unthreatened by overlapping areas of compe-

tence, performed so smoothly together that they presented a false picture of team collaboration as an easy, simple process. Sometimes the demonstration team operated with a subtle skillfulness that threatened the local professionals who attributed miraculous "know-hows" to the team collaboration. Too often, the teaching in the demonstration was focused on the medical diagnosis or the social factors, and very little was directed to the team process of making the evaluation or formulating the plan of treatment.

Left on their own to conduct a clinic, the Pasadena team began the slow process of learning their roles and the art of team collaboration. In so doing, personal feelings, agency loyalties, differing value systems, and discipline methodologies had to be dealt with. It is to their credit that the Pasadena team has not only learned how to function together, but benefiting from this experience, has attempted to set up procedures for ongoing training and involvement of other team members.

The staff, in addition to achieving smooth clinic functioning and providing good service to patients, has seen public education about its services and about mental retardation as part of its responsibility. It has presented case histories and historical overviews of the clinic development to several Pasadena gencies: Visiting Nurses Association, Child Guidance Clinic, Family Service Agency. It has conducted similar programs in educational facilities training nurses and teachers, for example, Pasadena City College.

The Pasadena clinic has some problems that are pertinent to almost all current agencies providing services to the retarded: the waiting list, the need for a full-time social worker, and the need for enough trained alternates to fill in when a regular team member is ill or leaves for some reason.

The impact of the Pasadena clinic has been most dramatically shown in a new development in the public school system in Pasadena. The school system has set up a Special Education Clinic identical in format with the Child Development Clinic. At first this was conducted as a pilot demonstration but as of September 1964 the Special Education Clinic was permanently included in school programming and team positions were budgeted. The clinic team consists of a full-time psychologist, school social worker, speech therapist, school physician (who in this case happens to be a pediatrician), school nurse, and full-time secretary. The supervisor of the Special Education department acts as chairman at the staff meetings with the physician on the team. The clinic is set up to evaluate, with a multidisciplinary approach, children having school problems. The purpose is to achieve an educational diagnosis for school placement and to screen for children who are educationally handicapped or limited. At the staff conference the referent is present (teacher, principal, nurse) and the school system has made available substitute personnel to allow the referent to participate. Followup is assigned to the school psychologist, thus providing an opportunity to evaluate the recommendations made at the case staffing. A number of special consultants are available: curriculum supervisors, opthalmologists, neurologists, psychiatrists, etc.

The Special Education Clinic has demonstrated its value so well that the superintendent of the school system has requested that the services be extended to all children who are facing suspension or exclusion, due to school problems. It is felt that this approach has resulted in better evaluation and educational planning. The best evidence for this is the recommendations now being made for budgetary increases for additional staff to permit expansion of the Special Education Clinic services.

The Pasadena clinic has also helped to identify the important role health departments can take in establishing child development clinics for early screening and case finding. The Los Angeles County Health Department is now developing such a program. The health officers of Long Beach and Pasadena (both sponsors of local child development clinics developed through the Childrens Hospital Traveling Clinic Project) have met with the administrative representative of the Los Angeles County Health Department and have helped to stimulate the development of a countywide program to develop such screening clinics.

The Pasadena clinic has continued to make use of other community resources and to seek consultation from State health department staff. The Child Development Project at Childrens Hospital took heed of the Pasadena experiences as other traveling clinics were developed. This has resulted in earlier planning with community representatives in regard to funding bases, firmer commitment by participating agencies, and closer medical alliance for the ongoing community clinic. Recognition has been made of the need for better selection of team members (based not alone on interest and availability, but on ability to teach and work with others as well) and also on the need to focus more closely on teaching professionals to operate together as a team. The Pasadena clinic has shown, by its experience in the past 4 years, that integrated community efforts can utilize existing programs to provide not only a new service but a service which results in more effective community help to the person in need.