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ABSTRACT

Services discussed are directed toward providing relief to parents charged with full-time care of a retarded child. The manner in which this respite care can be provided are explored in areas in or out of the home, on a regular or intermittent basis, and involving additional services. Homemaker, nursing, and babysitter services, as well as foster, temporary care, family-group, and group homes are described and several model programs are cited. Halfway houses, specialized nursing services, and state residential facilities are mentioned, while facilities offering respite care are listed. (RJ)

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for the Retarded

AN INTERVAL OF RELIEF FOR FAMILIES



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Respite Care for the Retarded

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Mrs. Marianna Paige, Consultant

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"MENTAL RETARDATION in itself is rarely sufficient cause for the removal of an individual from his natural home. Nonetheless, more than 200,000 retarded persons in the United States currently live in publicly operated residential programs. These residential facilities should offer services to retarded individuals, specifically to those severely and profoundly retarded, and those with multiple handicapping conditions, who require specialized programs.

"Ideally, short-term programs should be made available to the retarded with emotional, social, and/or medical problems who require intensive treatment or training within a sheltered environment. Further, model short-term programs should include temporary, reserved space and respite care to relieve critical family situations.

"In addition to providing services to the retarded, residential facilities should offer a variety of programs to the family. Every effort should be made to maintain family integrity through intensive counseling and supportive services for the individual and his family before, during and following residential placement. Alternatives to residential placement should be explored thoroughly with parents and community agencies."

**From RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED:
An Action Policy Proposal,
The President's Committee on Mental Retardation, 1970**



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Foreword

Since the beginning of history, man has had to deal with mental retardation. During different historical periods the handicap has been looked upon with varying degrees of scorn, pity, protectiveness, and in some cultures with awesome respect. Today, in the United States, we have accepted the fact that there are over 6 million individuals who are, or will become, mentally retarded. The fact that mental retardation can strike anywhere, that it knows no social or economic barriers, has been impressed on the public through all information media.

In 1963, Congress enacted the first major Federal legislation for specific assistance to the mentally retarded. Since that time, there has been a concerted effort to initiate new approaches in the training of professionals to work with the retarded, to diagnose their difficulties, to treat their disabilities, to train their minds and shape behavior, to cultivate their potential for rewarding activity and, equally important to counsel and assist their families.

The impact of retardation on the community is made more relevant with the realization that 95 percent of the retarded population are in the community living at home with their families, and therefore, require community services. In recognition of this need, respite care programs are emerging throughout the United States, as important components in the continuum of services to the retarded. While elements of respite care have been provided in the past by churches, neighbors, and relatives, or by private nursing facilities, it is only recently that respite care has emerged as an integral part of the planning for comprehensive community services.

This publication illustrates newly emerging services, across the United States, which are directed primarily toward providing a measure of relief for the families of the retarded. Very few people realize the burden on a family who have a

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retarded child to care for, day in and day out, around the clock. These families, and the mother in particular, need some form of relief from this physically taxing work. With State institutions and day services for the retarded filled to capacity, how is the mother ever going to get rest and help in her predicament, answer questions born of frustration and emotional strain, and receive a measure of relief from her daily anxieties? It is this urgent need that must be addressed in building a foundation of comprehensive community services for the retarded—services directed to assist the *family* in areas of training, counseling and rehabilitation.

It is in response to the needs of the families of the retarded, that respite care programs are emerging in communities across the United States. The variety and scope of these services vary with the needs of the family and the community, in direct correlation to adjunctive community services.

The purpose of this study is to focus attention on this major area of deficiency in professional planning for a continuum of care for the retarded, and focus on the need for truly comprehensive programs which include a system of supportive services to the family of the retarded. This study illustrates the ways in which these needs are being met in different community settings in answer to the growing demand for respite care services across the nation.

ROBERT I. JASLOW, M.D.
Director, Division of Mental Retardation
Rehabilitation Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare

Acknowledgments

Publication of this report has been made possible by Dr Robert I. Jaslow, Director, Division of Mental Retardation, Rehabilitation Services Administration, Social and Rehabilitation Services, Department of Health, Education and Welfare.

The author was privileged to have access to the expertise of many professional disciplines in the Division of Mental Retardation and on the President's Committee on Mental Retardation. These staff members gave freely of their experience and time in gathering data, directing the search into new areas and, most of all, creating a climate conducive to thoughtful evaluation and definition of what comprises a program of respite care, its place in the community, and in the continuum of comprehensive services to the retarded.

Special appreciation is expressed to Miss Doris Haar, Chief, Clinical Services Branch, and Mrs. Marjorie Kirkland, Social Work Consultant, Clinical Services Branch of the Division of Mental Retardation; to Mr. Fred Krause and Mr. Francis X. Lynch of the President's Committee on Mental Retardation; Mr. Richard A. Lippke of the Secretary's Committee on Mental Retardation; and to Mr. Gene Patterson, Residential Services Consultant of the National Association for Retarded Children, for their cooperation in making resource materials available.

Acknowledgments are also due the countless parents who shared their anxieties and heartaches in an attempt to make their needs known. It is for all of them that this study has been completed, with the hope that it will help, in some measure, to provide the services they so desperately need in the care of the retarded.

Mrs. Marianna G. Paige

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Respite Care Services

Respite care is defined as appropriate services, in a variety of settings, provided for the care of the mentally retarded person through temporary separation from his family, in or outside the home, for short, specified periods of time on a regular or intermittent basis, and involving other services as needed on an individual basis, for the purpose of relieving the family of his care in order to: (1) meet planned or emergency needs; (2) restore or maintain his physical and mental well being; (3) initiate training procedures in or out of the home.

Services performed in the home

Homemaker Services

Homemaker services are designed to bring a qualified, trained person into the home to care for the retardate, supplementing parental care and maintaining family unity. Crises, such as illness or hospitalization of the mother, the birth of a new child, or a death in the family, are often causes for serious family disorganization and can lead to premature or unnecessary institutionalization of the retarded member. The homemaker can provide temporary care so that the family can participate in activities outside the home while a responsible person cares for the retarded member. In some instances, homemakers also serve effectively as teachers, demonstrating better methods of child training and home management. The service is not designed for permanent care, but rather for transitory or temporary periods of need.

Nursing Services

Nursing services are most frequently provided through the Visiting Nurse Association or public health nursing services in the community. They are intended for a person requiring limited medical or nursing care which can be administered at home. A nurse aids the retarded individual, and trains mem-

bers of the family in methods of self-help, nutrition, and habilitation techniques.

Qualified Baby-Sitting Services

Groups of "baby-sitters," trained to work with the retarded and handicapped, are becoming more prevalent in communities across the United States. Initiated, for the most part, by parent groups, intensive training programs are taught by professionals in the field of mental retardation. Trained baby-sitters have provided a large measure of relief for families with retarded children, when other services were not required or available in the community.

Services performed outside the home

Foster Home

The licensed foster family is paid for board and residential expenses. To provide the opportunity for personal relationships, and to maintain the familial character, no more than three placements are made to any single foster home. The foster home can be utilized for short-term respite care, as interim placement prior to institutionalization, or as a trial placement between the institution and independent living in the community.

Temporary-Care Home

A licensed temporary-care home is a foster home providing short-term emergency care for a retarded child or adult outside his own home during family emergencies or vacations. Placement relieves parents of the pressures imposed by constant care. The service can extend from qualified daily "baby sitting" to care of a retarded person for weeks or months.

Family-Group Home

The essential difference between a family-group home and a foster home is in the number of persons placed in the facility. A family-group home usually cares for four to six retardates of similar age and level of development. Emphasis is placed on peer group experiences. Short-term care for emergency placement, for family vacations, or for trial separations from the family, is accepted by some homes. Where supporting programs are available, family group homes may

be appropriate for the mildly and moderately retarded. In rural areas, such supplementary programming as work activity, sheltered work, or occupational activity may be provided in the home.

Group Home

This is a single dwelling or apartment unit owned or rented by an agency caring for a group of from seven to twelve individuals. Staff are paid employees and viewed as counselors or house parents. This setting, by virtue of its size and staff, provides a homelike atmosphere, although relationships of staff are significantly different from those in foster homes. For those who maintain close relationships with their own families, but are unable to live with them continuously, this facility may be more suitable than a foster family.

Halfway House

The halfway house is designed primarily to provide a bridge between the State facility, the foster home, and the community. It offers living arrangements for the retarded person who has demonstrated a certain amount of independence and self-determination. While residents of a halfway house may eventually move into the community and live independently, short-term placement can be arranged to determine readiness for independent living and effects of trial separation from the family, or as an interval for evaluation and additional training for independent living. Residents may work in the community and care for themselves and their own quarters. They are assured of assistance in budgeting their money, with personal supervision and counseling as the need arises.

Specialized Nursing Services

The nursing home provides professional nursing care and related medical services 24 hours a day. A person eligible for nursing-home service must have a clinically determined illness or condition, diagnosed by a physician and requiring medication or medical and nursing care. Such needs, however, (1) do not require care in a general or special hospital; (2) cannot be met in the patient's own home or some substitute home; or (3) cannot be met satisfactorily in a physician's office, clinic, or other ambulatory care setting.

State Residential Facilities

Historically, State facilities offered custodial and terminal placement for the retarded. However, decisive changes in both the philosophy and practice of residential services to the retarded are emerging nationwide. Today's progressive institutions no longer separate families; rather they provide adjunctive services to maintain the family unit. In some States, the facility has become a part of the community. Open-door policies permit admission, whenever there is need for specific services, and discharge when the services are no longer needed.

An ever increasing number of residential facilities have established short-term admission procedures, with flexible entrance and discharge requirements for trial separation from the family, residence during a family crisis, needed medical treatment or evaluation, interim placement before admission to a foster or community group home, or as a corrective measure in behavior modification or training.



Selected Models

The following examples of respite care were selected categorically, as representative of applicable services, in a variety of settings.

Services performed in the home setting

Homemaker Services

In an effort to bring together two social trends—growing concern for the retarded in our population, and increasing recognition of homemaker services in helping families cope with situations of stress—two voluntary agencies in New York City carried out a three-year project to demonstrate the potential contribution of homemakers and other home helpers toward preserving families of the retarded.

Established to examine systematically the effectiveness of homemaker and other home-help services to families with retarded children, the project was conducted cooperatively by the Retarded Infants Services, Inc. (RIS), and the Association for Homemakers Services, Inc. (AHS), with support from the Department of Health, Education and Welfare Children's Bureau. The project was based on the conviction that such services have an important place in the chain of services required by families of the retarded at various times in the retarded person's life.

The project focused on 35 families. Twenty-four had been referred from general hospital clinics, six from the New York State Department of Mental Hygiene, three from clinics for the retarded, and two from private physicians. The intake social worker's determination that the family needed homemaker service was the basis for selecting the family for participation in the project. The only criteria were that the family

have a mentally retarded child under 5 years of age and appear able to benefit from the presence of a helper in the home.

The following case exemplifies homemaker service in its complete sense. The steadying influence of the homemaker, working in partnership with the parents, resulted in a decrease of tensions in the home, increased the parents' understanding of their problem, and avoided an institutionalization that could have been harmful to both the child and the parents.

Mr. and Mrs. A. were referred to RIS by a diagnostic clinic. At the time of referral their retarded child, Amy, was 4 years old. Her brother James, 9, had normal intelligence. Mr. A was unemployed because of a strike. Mrs. A said she was at the breaking point because Amy was completely unmanageable, could not be left alone at any time, and had proved to be a tremendous burden to James, who had to take care of her some of the time.

Both parents seemed immature, demanding, and manipulative. A severe marital problem had developed out of conflict around Amy. The mother was particularly anxious, describing herself as confused, forgetful, and fearful of harming Amy. Mr. A and his parents were pressing her to send Amy to an institution. Mrs. A was not yet ready to do so.

RIS referred the case to AHS, which sent a homemaker into the home. She was trained to help the mother carry the burden of household management and child care, and to observe changes in behavior and attitudes. Part of her task was to help determine whether Amy was educable.

Under the regular supervision of the AHS caseworker, the homemaker assumed a nurturing, maternal role with both the children and the parents, taking care not to encourage lingering dependency. Amy responded well to her special attention and soon showed remarkable improvement. Mrs. A apparently had been too tense to bring out Amy's potentials.

James, too, improved. Relieved of Amy's care, and receiving more attention from his parents, he soon seemed less withdrawn, and behaved in a more forthright and constructively aggressive manner.

Mrs. A seemed more relaxed, as she now had some time for her own needs. The tension between the parents also relaxed a little, and both seemed to have less need to reject Amy.

The AHS caseworker kept in regular touch with the staff of the referring diagnostic clinic, who soon reported that the



homemaker services had helped clarify the condition of the child and the dynamics of the family situation. It was then agreed that the AHS caseworker would take over the family counseling role from the clinic, and would attempt to bring about better relations between the parents by helping them both to a better understanding of the needs of their retarded child, of their normal child, and of each other. As a result, Amy entered a special day class for the retarded, instead of an institution.

Home Training Specialists

The services of home training specialists are provided free to six Southwestern counties of Wisconsin as part of the Central Wisconsin Colony and Training School's Project Six. This project was originally a community services demonstration funded by the Division of Mental Retardation, Department of Health, Education and Welfare.

The home training specialist, trained in a variety of disciplines by professionals in the field of mental retardation, visits families with a retarded child living at home. Her training includes instruction in home-training techniques, as well as in the causes, effects, and rehabilitative potentials of retarded individuals. She helps the family with problems encountered in the home, and establishes procedures aimed at teaching the parents to train their child more effectively.

The purpose of the service is to help families keep their retarded child in the home. When other ancillary services are needed, the home training specialist refers the family to community agencies or institutions serving the retarded. Monthly visits by the home training specialist provide a continuum of care, until she and the parents together decide that the family no longer needs assistance.

Services performed outside the home

Public Residential Facilities

The State of Connecticut was among the first to recognize that a new concept in residential services to the retarded was needed. Traditionally, admission to an institution for the retarded was considered terminal placement. A child's admission constituted a significant break from his previous exist-

erice, being a permanent solution to the problems that had necessitated institutionalization.

A new system of admissions was designed to meet immediate needs of both the parents and the retarded individual. Permanent Probate Commitment was replaced by voluntary or informal admission. This procedure permits short-term residence for retardates in State facilities, with guardianship remaining with the parents. Parents are now able to secure residence for respite care during acute family stress, for short-term residential evaluation of the retardate to determine suitability for independent or semi-independent living, or to allow the family vacation time. Short-term admission can be for 24 hours to six months.

The Director of the New Haven Regional Center, New Haven, Connecticut, describes respite care in the center thus:

We consider our foster home program part of our residential care program. Residential care is of two types, short-term and long-term. Short-term care could be for an hour, for overnight, or for a weekend.

It is a real responsibility to provide short-term care; it is also very valuable to families. I think it is probably more beneficial for mother and father than it is for the child who may be upset by coming to a strange place for the night. Thus, we may not be doing much for the retarded child therapeutically, but I think we're doing a lot for mother, father, and siblings who might be able to do things together which they could not have done if they had the retarded child with them. We're striving constantly to keep our beds in use. We try to plan so we know by Wednesday which beds will be open Friday night, Saturday, and Sunday. This is probably one of the most valuable services, and probably one of the most active areas in which our social services staff operates. We often have to say no; sometimes we don't have enough beds available at the time. It's disappointing to parents, so we try to have them plan ahead. I don't know how you can plan ahead for emergencies, but if it's an emergency we try to respond to it.

Temporary Care Homes

WISCONSIN

In the last year, two new temporary-care homes have been initiated in Wisconsin, under the auspices of the Lafayette and Sauk Counties Social Service Departments. The two homes provide short-term emergency care for retarded children on an



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hourly, weekly, or monthly basis. A minimal fee is charged, determined by the financial capability of the parent.

The temporary-care home mothers received specialized training on mental retardation, with courses designed to effect toilet-training, self-feeding, dressing and personal cleanliness.

Additional training was provided at Central Wisconsin Colony Training School in workshops with social workers, physical therapists, aides, and nurses to observe training and care techniques, health and safety procedures, and disciplinary methods.

The homes are available 24 hours a day, throughout the year. They are licensed by the counties to care for a specified number of retarded children, with a specified number of beds guaranteed to be available for short-term, emergency-care clients.

CALIFORNIA

In August, 1969, a new concept in care for children with mental or physical handicaps was initiated in Marin County, California. The "Big R" Respite Care Home provides three weeks of out-of-home care for five selected and grouped children each month, throughout the year. Designed primarily to provide an experience in social development and independent living, this home also makes it possible for parents of handicapped children to obtain some relief from their constant care-taking responsibilities.

In accordance with the philosophy that the respite care home provides a service to children and parents, and should be available without becoming an undue financial burden to the family, funding for this project is provided largely through community organizations, a foundation grant, and other public support.

CONNECTICUT

In Bridgeport, two homes were established under private auspices—the local parents' association—to provide continued community living for retarded individuals whose normal family life was interrupted or terminated. The homes were planned to permit temporary quarters when needed, to avoid hasty placements at State institutions resulting from family crisis, placements that might otherwise continue beyond the crisis.

Additionally, the homes could serve residents for terminal placement.

The Bridgeport homes were also planned as "life insurance" or "peace of mind," to allay the fear that institutionalization would follow any parents' incapability. The belief that continued care could be provided in a home setting has been a deep source of satisfaction to members of the parents' association.

Short-term residential care programs

WISCONSIN

Short-term care was inaugurated on a trial basis in Wisconsin's State Colony and Training Schools in 1965, and since that time has gradually developed into an integral part of the institution's program. The service continues to be in demand and reaffirms the State institution's role of supplementing community services as part of a continuum of care for the retarded.

Any adult retarded resident of the State of Wisconsin is eligible and may apply for voluntary admission consistent with the purposes of the program. Parents or legal guardians may apply for minors.

The Short Term Care Program was established to provide a brief, prearranged admission to a State colony and training school for the following purposes:

1. To provide care for selected retarded persons where the parents or guardians require respite from total care responsibilities.
2. To provide care and treatment for those cases where admission may delay or eliminate the need for long-term care.
3. To provide through a Development Evaluation Center a diagnostic and evaluation service which the local community is unable to provide, but which is essential to the person's continued care and treatment in his home or community.
4. To provide care for retarded persons admitted for research purposes.

5. To provide medical, nursing, and other necessary treatment for retarded persons when family or community resources are temporarily unable to offer required care and services.

TENNESSEE

Clover Bottom Hospital and School, a Tennessee State facility serving approximately 1,400 residents, initiated a program in April 1969 making 10 beds available for short-term respite care service. In one year, 80 families were served. The success of the program effected a dramatic reduction in the priority waiting lists for institutionalization.

Admissions are voluntary, and residence generally does not exceed 30 days. Principal reasons for admission are as follows:

1. Illness or death in family of retardate.
2. Behavior modification and training for retardate.
3. Medical control or evaluation.
4. Vacation period for family.
5. Interim placement before transfer into foster home.
6. Determination of effects of separation between family and retarded.

CALIFORNIA

The State of California has passed enabling legislation for the purchase of services through regional centers. The State's Human Relations Agency, in the last year, has placed more than 900 mentally retarded from State hospitals in residential accommodations in their own communities. Placements are made in qualified boarding care facilities or licensed private institutions. The program is centered around the foster-home concept and is designed for persons who can benefit from living in a private family atmosphere in their own community.

The community placement program was designed to give more home-like care as well as to be economically sound. California estimates the cost of maintaining a mentally retarded person in a family care program is \$2,200 to \$3,500 less per year than confinement in a State hospital.



MINNESOTA

In 1968, the Fergus Falls State Hospital, Fergus Falls, Minnesota set aside 10 beds for short-term residential care for mental retardates.

Admissions procedures are kept flexible to provide care during emergency situations, for parental vacations, and to provide short-term residency for evaluation and training of the retarded individual. Parent counseling and training has been included in these services to enable them to help the patient to continue the behavior and social skills initiated by staff during residency.

The Fergus Falls community shares a deep involvement with the county and State in the joint sponsorship of nine group homes serving approximately 50 adult retardates. Adjunctive training and habilitation are provided through rural work programs and a sheltered workshop facility in the community. Two additional homes are maintained by the sheltered workshop for those clients who live too far away for daily commuting. County case workers review clients monthly to determine the most beneficial placement in the community, and schedule additional therapy or services as required.

WASHINGTON

The Home Care Counseling Program, initiated at Washington State's Fircrest School, is operating under a three-year Federal grant to provide training of parents and concerned community professionals in the development of home care programs for severely handicapped, mentally retarded children. The program was designed to give them maximum opportunity for development within the family setting. Under the program, children come from home to live at Fircrest as guests for a limited period of time. They have had medical and psychological evaluations before arrival and the parents agree to spend time each week with the children in the resident hall.

The program for the children includes a specific schedule of daily activities following an initial two-week observation period. Most of the children stay at Fircrest Monday through Friday, and go home on weekends. The child's program in the residence hall includes such practical matters as behavior, management, feeding, and problems of personal hygiene. With individual training, it is possible to develop self-help skills that

can be continued at home, thereby avoiding permanent institutional placement.

The program provides places for 16 children for whom regular comprehensive progress appraisals are made. Weekly staff meetings, which may include visitors such as other physicians, social workers, teachers, or nurses, evaluate the practical aspects of each individual program.

TEXAS

For three summers, five State schools for the mentally retarded in Texas offered residential programs for trainable and educable retardates. These programs provided meaningful group experiences for the participants, a respite from the care of their children for the families, a resource for community agencies, and an evaluation period for families and school personnel. A survey at the end of the sessions indicated the programs had definable benefits for parents, children and staffs.

The first program at Denton State School was designed to provide temporary institutional care of trainable and educable retardates. The 30-day program served 62 persons ranging in age from 6 to 42. All were eligible for admission to one of the State schools for the mentally retarded, but had not been admitted because of reasons such as, an insufficient number of beds, status of applications, or conflicting family plans.

The purposes of the Denton summer residential care program were as follows: to give the participants a meaningful group experience while separated from parents, as well as the development of new relationships; to allow families to determine whether placement of their children would be in the best interest of all family members; to provide temporary relief for families from the task of caring for the physical needs of their children; to serve as a temporary resource to community agencies frequently overburdened during the summer; and to allow school personnel to evaluate the students and their families while the retardates were in residence.

Accordingly, in summer, 1967, the Abilene, Austin, Mexia, and Travis State Schools joined the Denton State School in a temporary residential care program for mental retardates. These institutions provided similar programs in summer, 1968, with advancements made in numbers served, programs offered, and purposes fulfilled.

There were significant similarities in the programs of the five State schools: programs served the same diagnostic groupings, and all participants were potential candidates for admission to a school for the mentally retarded; staff members evaluated participants individually, considering the needs of the participant, the strengths of the family, and the resources for the mentally retarded in their communities; and evaluations were developed through counselling, psychological studies, and observations of the child in stimulating educational and recreational programs.

Prior to the inception of the program, residents going home for summer vacations were placed on furlough status and facilities were reserved for their use in September. When Federal grants and accelerated volunteer programs became available, however, staff members sought new ways to deliver services to mental retardates through the efficient utilization of all facilities during the summer.

The temporary residential care programs differed in numbers served and in length of sessions. In summer, 1968, the Abilene State School provided a three-month program for 64 students from ages 6 through 29, 22 of whom were admitted at the end of the summer. The Austin State School had two one-month sessions for 32 students between the ages of 5 and 16, while the Mexia State School accepted six students ranging in age from 6 to 35 and admitted all of them by the end of the summer. The Travis State School provided two one-month sessions for 18 boys from ages 8 through 20, and the Denton State School extended its program to serve 109 students during three 17-day sessions.

In 1968, these schools offered programs organized along similar lines, but again differing in numbers served and in length of sessions. The Abilene State School served 47 students, 26 of whom were admitted before the end of the summer. The Austin State School accepted 35 students ranging in age from 5 to 23, while the Mexia State School had a program for 14 students which included a day camp at a nearby lake. Twelve boys participated in two four-week sessions at the Travis State School, and 66 students attended two one-month sessions at the Denton State School.

At the end of the 1968 summer residential care programs, questionnaires were sent to the families whose children participated in the programs of the Abilene and of the Denton State Schools. Most were returned, and the results indicated that



more than 50 percent of the children and the families involved benefited from the program.

Qualified baby-sitting services

A unique program of baby-sitting services for exceptional children has recently been inaugurated in the Reno-Sparks area of Nevada.

One of the most difficult problems for parents of an exceptional child, especially when the child is retarded, is to find some relief from the constant care, the never-ending watchfulness they must provide.

Through a new service within the community, they can now find a trained babysitter to watch over their mentally retarded child while they are away on necessary shopping trips, on visits to the dentist, to the doctor, or even attending a movie when husband and wife can go together.

A group of older people, most of whom are presently working as foster grandparents with the mentally retarded children at the Nevada State Hospital, have established this babysitting service. These foster grandparents are trained in institutional settings to care for the mentally retarded, and now have some preparation for the special type of babysitting involved in such a program.

This program is jointly sponsored by the mental retardation service of the Nevada State Hospital, the Foster Grandparent Program, and the Washoe Association for Retarded Children.

National Sponsorship

Under the auspices of the National Association for Retarded Children, over 15,000 members of a Youth Auxiliary have received training in the care of the retarded. In most communities orientation and training is a cooperative venture between Health and Special Education professionals, paramedical staff from local hospitals and institutions, and volunteer organizations.

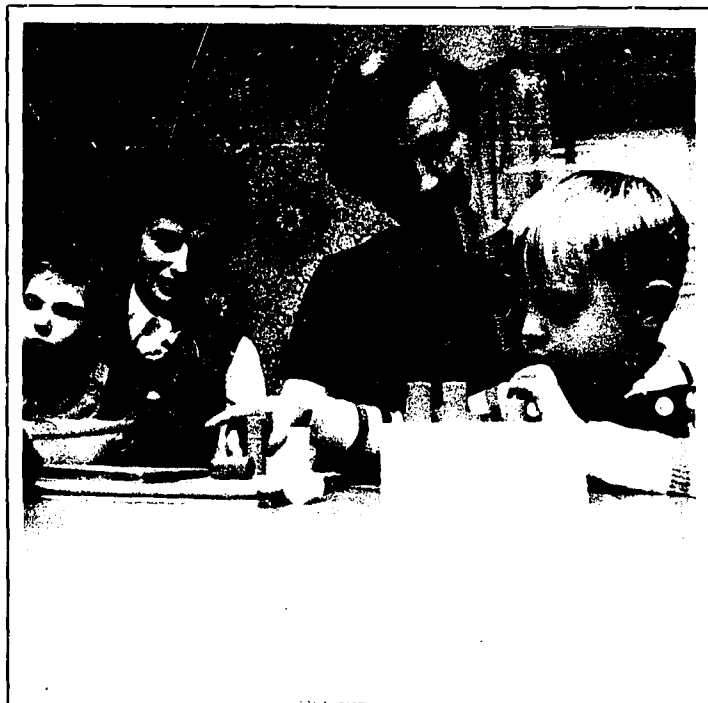
For the most part, these young people establish a deep bond of friendship and affection with their retarded charges, taking them on outings and helping them and the family to realize a greater degree of independence.

Private and Community Sponsorship

The Childcare Assistance Program for Special Children was initiated to serve the greater Washington, D.C., area in August, 1969, by 30 members of the Fairfax County Town and Country Junior Women's Club. The service provides temporary care for handicapped and retarded children, through the services of qualified, trained sitters.

The "sitters" have been trained by specialists in nursing, therapy, and psychology to provide temporary boarding care for retarded and handicapped children, either in State licensed homes or privately in the sitter's own home. Care ranges from 24 hours up to six months in cases involving infants prior to permanent placement.

Sponsorship of the group comes through the Northern Virginia Association for Retarded Children, with referrals through social agencies, hospitals and church and civic organizations.



Facilities Offering Respite Care Services

The following organizations provide respite care services described in the body of the report. They were selected as representative examples of the variety of services being performed in the United States.

Retarded Infants Services, Inc.
386 Park Ave. South
New York, N.Y.

Association for Homemaker
Services, Inc.
432 Park Ave. S.
New York, N.Y.

Central Wisconsin Colony &
Training School
317 Knutsan Drive
Madison, Wisconsin 53704

New Haven Regional Center
455 Wintergreen Ave.
New Haven, Connecticut 06515

The Big R Respite Care Home
520 Alameda de la Loma
Novato, California 94947

Parents & Friends of MR
Children of Bridgeport, Inc.
4695 Main Street
Bridgeport, Connecticut 06606

Clover Bottom Hospital & School
Stewarts Ferry Pike
Nashville, Tennessee 37214

California State Department of
Mental Hygiene
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Abilene State School
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Mexia State School
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National Association for Retarded
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