Three New Mental Retardation Service Models

Implications for Behavior Modification

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Three New Service Models for Mentally Retarded People

Every year new service models are demonstrated by energetic professionals who are seeking better ways to serve mentally retarded people (e.g., Menolascino & Stark, 1984). The new models are constantly challenging behavior modifiers to broaden their horizons or risk the possibility of becoming outdated (Reiss, 1987). In this chapter, we will consider three new models for serving people with mental retardation and discuss some of the ways in which behavior modifiers might relate to these models. The models are outpatient mental health services, inpatient mental health services, and foster care. Two of the models, outpatient and inpatient mental health services, relate to the critical need for services to people who are dually diagnosed (i.e., mentally retarded and emotionally disturbed). The third model, foster care for persons with mental retardation, provides a desirable alternative to residential placement in state institutions and other restrictive environments. Although the three models discussed here are from Illinois, similar programs have been created in many places across the United States. Thus, the models are relevant to important national trends in the field of developmental disabilities. Because two thirds of this chapter is concerned with behavior modification and service models for the dually diagnosed, our discussion begins with a consideration of general information on the importance of increasing the supply of mental health services for mentally retarded people.
MENTAL HEALTH NEEDS OF MENTALLY RETARDED PEOPLE

Historically, behavior modifiers working with mentally retarded people have concentrated their efforts on the treatment of severe behavior disorders. As important as this contribution has been, the treatment of severe behavior disorders represents only a small part of the total mental health needs of mentally retarded people. For every mentally retarded person who needs treatment for a severe behavior disorder, there are 10 who need training in social skills, and 2 who need treatment for depression. Although severe behavior disorders are important problems that should be treated, there is no justification for concentrating on the treatment of these problems to the point that other, more prevalent disorders are virtually ignored. Yet this is what happened during much of the period from 1960 to 1985.

There is a need to broaden the behavioral approach to include the treatment of the full range of mental health problems. The development of behavioral programs for social skills training was a major step in this direction. We need to continue these efforts and to develop treatments for other under-served mental health problems, such as depression (Kazdin, Matson, & Saturnore, 1983; Sovner & Hurley, 1983), anxiety disorders (Matson, 1981; McNally & Ascher, 1985), and personality disorders (Eaton & Menolascino, 1982; Zigler, 1971). We believe that the behavioral approach should be adapted to address the full range of mental health problems with mentally retarded people.

Prevalence

The importance of developing behavioral treatments for persons with dual diagnosis is suggested by a number of prevalence studies (Lund, 1985; Philips, 1967; Philips & Williams, 1975; Reiss, 1982). There are numerous findings that the prevalence of emotional disorders is much higher among mentally retarded than among nonretarded people (Dewan, 1948; Rutter, Tizard, Yule, Graham, & Whitmore, 1976; Weaver, 1946). Jacobson's (1982) survey of mentally retarded people in New York State found that about 1 in every 6 mildly mentally retarded adults had a mental illness. Other surveys reported even higher estimates, with some studies suggesting that as many as one third of all mentally retarded persons may need mental health services (Matson & Barrett, 1982).

Steven Reiss recently completed a survey of a fairly random sample of 205 mentally retarded adolescents and adults from 17 community-based day programs in the Chicago metropolitan area. The sample included 94, 73, and 35 people with, respectively, mild, moderate, and severe mental retardation (the level of mental retardation was unknown for 3 subjects). The age range was from 18 to 79; there were 82 women and 123 men. The ethnic background comprised 126 whites, 53 blacks, 15 Hispanics, and 10 "others."

In the first part of the study, the Reiss Screen for Maladaptive Behavior was completed by caretakers who knew the subjects well. The Reiss Screen