How One Health Department Helps the Handicapped

By MURRAY GRANT, M.D., D.P.H.

FOR several years, the Cattaraugus County Health Department has participated in the New York State medical rehabilitation program, which arranges for the diagnosis and treatment of physically handicapped children under the age of 21 and of persons of any age with poliomyelitis.

However, participation was not without its obstacles. Chief of these was the local lack of recognized specialists in rehabilitation. As a result, almost all patients eligible for rehabilitation service had to be transported from Cattaraugus County to Buffalo, approximately 70 miles away. Moreover, the expense was imposing an additional tax burden on the people of Cattaraugus County, a rural county of 80,000 with a median income below the median for the United States, where the tax burden was already increasing every year.

During 1953, a survey by the author found that a considerable proportion of the total expenditures for rehabilitation went for treatment of cerebral palsy and poliomyelitis cases and that most of these funds were expended for physical, occupational, and speech therapy. Most patients remained in Buffalo or at a treatment center near New York City for months. During their absence from home, particularly in the case of cerebral palsy patients, the initial zeal with which parents accepted treatment for their children was often transformed into lack of interest and even fear of the burden to be reassumed when the children returned home.

The staff of the county health department felt that, if there were a sufficient number of patients in the county to warrant it, an outpatient clinic staffed by full-time, physical, occupational, and speech therapists and operated by the health department might offer certain advantages:

1. The health department could initiate a rehabilitation program for both children and adults. Many children are not seen under the State rehabilitation program, and therapy is not available to all adults.

2. Patients could be seen 2 or 3 times a week and could continue to live at home instead of being separated from their families for weeks and months.

3. Parents of handicapped children could accompany them to the treatment center, where the parents could not only see what was being done for their children but also could learn how to continue the treatment at home.

4. The initial interest with which parents seek and accept treatment for their cerebral palsied children could be capitalized upon, because the parents would be able to share in planning the treatment.

5. The family physician could participate more actively in the program. Because children had been sent to specialists in Buffalo, away from the private physician, there had been some antagonism to the State medical re-

Dr. Grant, director of the Clay County Health Department, Liberty, Mo., was formerly commissioner, Cattaraugus County Health Department, Olean, N. Y.

habilitation program on the part of local physicians.

6. The new program would result in considerably less expenditure of funds, and yet service could be given to many more persons.

Organization

Specialists in rehabilitation felt that an outpatient clinic in the county would be worth trying. However, although the clinic team could be administratively responsible to the county commissioner of health, a qualified person would have to be responsible for medical supervision. Therefore, an orthopedist with special experience in cerebral palsy was recruited. He resides in Buffalo and visits the county four times a year to see patients, ascertain their progress, and recommend therapy.

The orthopedist remains at the clinic from 9 a. m. to noon. He examines the patients, evaluates their progress, and, if necessary, recommends continued treatment or surgery. He also sees new cases or cases in which there is a question of the value of rehabilitation clinic service—for example, a cerebral palsy patient with a low I. Q. For these children, he will usually recommend psychological examination, which is usually done at the county mental health clinic. For all patients coming directly to the clinic, the orthopedist dictates a progress report, which is sent to the family physician; if the patient is referred by a physician, the orthopedist telephones him to discuss the case and the findings and recommendations.

Investigation revealed that the number of known handicapped persons in the county warranted the establishment of a clinic staffed by full-time personnel, and the county health department included in its 1954 budget an item of approximately $12,000 for a rehabilitation clinic. The county board of health approved the item, and the board of supervisors, the appropriating body, included it in the budget. A most influential factor in their decision was the statement that expenditures would be reduced and services increased.

Recruitment of qualified personnel was difficult but was accomplished in time for the clinic to commence limited operations in March 1954. Clinic headquarters were established in the county health department in Olean, and an additional treatment center was set up in another area having a considerable population.

Transportation of patients to the treatment centers was expected to be a major difficulty. However, there has been surprisingly little difficulty and, on the 1 or 2 occasions when transportation has been an obstacle, arrangements have been made with volunteer workers to bring patients to the treatment center.

A nominal charge of $1 is made each time a patient visits the clinic or treatment center because we believe that it helps give to the families the feeling that they, too, are contributing to the patient's rehabilitation. No extra charge is made when patients are seen by more than one therapist. The fee system is flexible, and the charge is waived when the patient or his family is unable to pay. Only once has a parent declined further treatment for a child because of the fee, and she brought the child back to the clinic when the fee was waived.

So far, most of the clinic patients are children, who have visited the treatment center twice a week for several months. The policy is not to accept children unless they are accompanied by a parent, primarily to insure parent participation in the treatment program—by watching how the child is treated and by being shown what can be done for him at home. Practice at home is strongly encouraged, and the importance of not assuming that treatment at the clinic is sufficient is stressed. Each therapy session usually lasts half an hour; if a patient receives all three types of therapy—physical, occupational, and speech—he remains at the clinic for approximately an hour and a half.

Publicity

A program was arranged at a hospital staff meeting at which all three therapists described their services. To acquaint the public—particularly those who are possible sources of referral of patients, such as physicians, schools, and social agencies—with the clinic and what it is trying to do, the county medical society was kept informed of developments. Several newspaper articles were published, with pictures. Two local service clubs donated equipment, and pictures were taken of the presentation and

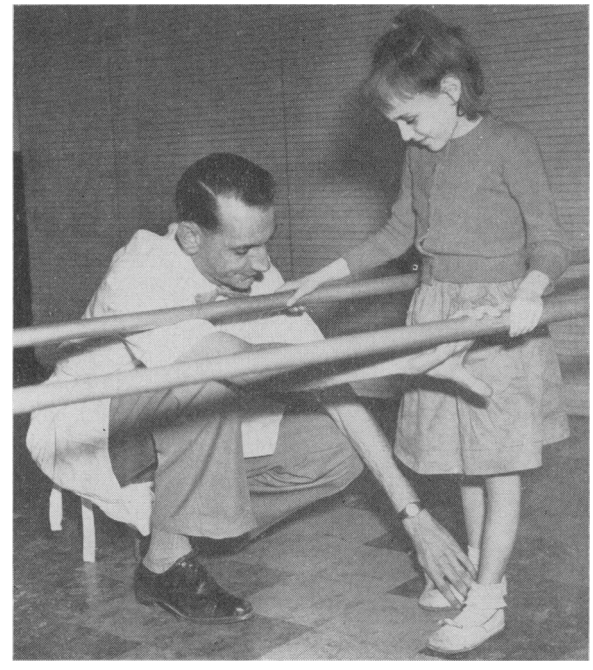
published in the local newspapers. The clinic was discussed at community meetings and, in the near future, a meeting will be held with all school authorities in the county to describe the clinic services. However, informing the public about the rehabilitation services is a slow process, which must continue indefinitely.

Convincing local physicians of the value of the rehabilitation clinic and persuading them to refer patients to it also must be a continuing educational process. Most physicians recognize that a patient with a speech defect can be helped, but the concept of occupational therapy or even of physical therapy is more difficult to appreciate. Physicians will be convinced of the clinic's value if they know that patients have been definitely benefited by the treatment received there. For example, after a patient with multiple sclerosis of many years' standing was helped, his physician referred another patient to the clinic.

Coordination of Services

Fitting the county rehabilitation clinic into other programs—the State medical rehabilitation program; a recently established county medical social service; a county mental health clinic; and the county public health nursing service—required special attention.

Coordinating the new clinic with the State medical rehabilitation program was comparatively simple because many children who receive surgery under this program are referred to the rehabilitation clinic. For example, a patient with a cleft palate will be referred for speech therapy following completion of the reparative operation. On the other hand, a person attending the rehabilitation clinic may require braces, which can be purchased under the State rehabilitation program.



Since the county medical social worker is familiar with the State rehabilitation program, she knows many of the patients attending the county rehabilitation clinic, knows their problems, and can help them or assist the clinic therapists in working with them. She can also serve as a liaison between the rehabilitation clinic and the mental health clinic. All recommendations for surgery, braces, or psychological tests are transmitted to her.

Many of the children attending the rehabilitation clinic require psychological testing to determine how much benefit can be expected from rehabilitation therapy. Adult patients who find it difficult to accept their physical handicaps present emotional problems which the mental health clinic team can sometimes treat. Also, when patients attending the mental health clinic are found to have physical handicaps, they are referred to the rehabilitation clinic.

Making maximum use of the public health

nurses in the rehabilitation clinic services, however, called for more deliberation. For several months, mainly because many of the patients attending the clinic were not known to the public health nurses, we pondered the part the nurses would take in the work of the clinic. It was finally decided that they would fit into the program:

1. By referring patients to the clinic and by making the service known to those in need of it.
2. By contributing to the clinic information about factors in the patient's history and background which might affect the treatment plan.
3. By becoming familiar with the needs of patients who require considerable home treatments.

The public health nurse observes treatment in the clinic and becomes acquainted with the patient and, if the patient is a child, with the parent. Then she visits the patient in his home and helps him or the parent learn to carry out treatment in the home situation. In addition, periodic conferences are arranged at which the clinic therapists, the medical social worker, and the public health nurse discuss the progress of the patient and any problems in the home or in the environment which may have a bearing upon the treatment plan and upon the prognosis. The public health nurse develops special skills accessory to the rehabilitation clinic through inservice training.

The rehabilitation clinic team has discussed the services offered by the clinic with the vocational counselor of the State department of education. He plans to meet with the clinic team at regular intervals to discuss cases and to determine whether rehabilitation clinic service would be more practical than to have services paid for under the vocational rehabilitation program.

Results

Since the clinic commenced operation, the following types of cases have been seen: poliomyelitis, cleft palate, delayed speech, arthritis, cerebral palsy, postural difficulties, multiple sclerosis, hemiplegia, tongue-tie, clubfeet, tight heel cords, old fractures, orthodontic defects with speech impairments, lisp, hearing loss, knee injury, encephalitis, stuttering, birth injury, stroke, and paraplegia.

The following cases reviewed indicate the results that can be achieved.

CASE 1. A little girl, now 4 years old, contracted poliomyelitis in 1953, when she was 2 years old. She was left with a weak and contracted right arm, which she could not use. Physical and occupational therapy were started at the clinic on September 22, 1954, and were continued twice a week until December 1954, when sufficient function had returned to the arm to allow her to use it in feeding herself and in play.

CASE 2. A 43-year-old man was diagnosed as having multiple sclerosis. When he was first seen at the clinic, on November 10, 1954, he could not walk except with a cane and by clinging to his wife. At the clinic he was taught crutch balance, coordination, and stair climbing, and within 6 weeks he was walking alone with crutches. Occupational therapy was then started to give him confidence and to train him to make a living.

The patient is now undergoing processing by the New York State Vocational Rehabilitation Bureau, with a view to possible placement in a job. In the meantime, he operates a neighborhood store, selling light lunches, groceries, and articles of leather which he has made at the rehabilitation clinic. His personality has changed completely; self-pity has turned to determination and hope. He is independent to a large degree and is again the head of his family.

By the end of 1954, patients had made 1,130 visits to the rehabilitation clinic; 78 patients had actually been treated, and many of these were still under treatment.

The 1955 health department budget for rehabilitation has been reduced by 36 percent, and this alone is a strong point in selling the program to those responsible for appropriating tax funds for health purposes.

Although much remains to be done, particularly in coordinating the clinic services with services offered by schools and vocational rehabilitation agencies, we feel that the rehabilitation clinic is the nucleus of a workable program aimed at helping the many handicapped persons, both children and adults, in Cattaraugus County.