

changing
patterns
in residential services
the mentally retarded

The President's Committee on Mental Retardation presents this group of papers as a contribution to the careful study and imaginative, people-related thinking and planning which must underlie improvement in services to the nation's millions of mentally retarded persons. The views expressed in these papers are the authors' own; the Committee has taken no position on these works. The Committee's views are presented in two reports made to the President of the United States - - **MR 67: The Nation's Progress and Remaining Great Needs in the Campaign. To Combat Mental Retardation** and **MR 68: The Edge of Change.**

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CHANGING PATTERNS IN RESIDENTIAL
SERVICES FOR THE MENTALLY RETARDED

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Washington, D. C. 20201 January

10, 1969

ACKNOWLEDGEMENT

The Committee gratefully acknowledges the support of the National Institute on Child Health and Human Development which made possible the reprinting of this volume.

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Part I: Challenge

Chapter 1

Why Innovative Action?

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The Problem

The Rationale of the Book

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WHY INNOVATIVE ACTION?

The Problem

In 1967, the President's Committee on Mental Retardation took stock of the national effort being made to combat mental retardation. In its report, MR 67 (President's Committee, 1967), one of ten points emphasized was the poor status of residential care. In fact, residential facilities were described as a disgrace to the nation.

Unfortunately, there is little good news when writing about residential facilities in the United States, although considerable and even outstanding progress is being made in some areas of mental retardation. Among these are the growth of day centers for severely handicapped individuals and of employment opportunities for retarded and handicapped individuals in general. Throughout the country, programs in public education have helped to dispel some of the darkness of the past. Research--biological, sociological, and behavioral--is a hallmark of the American scene. Volunteer efforts for both the retarded and the physically handicapped have been outstanding. Innovations in behavior shaping are pointing the way for better management. Diagnostic services for the retarded also have been among the outstanding successes.

Why, then, have residential facilities in this country lagged so far behind these other areas in which advancement has been considerable? What are some of the problems which seem to confront our residential facilities?

Typically, public residential facilities have been plagued by a triple problem: overcrowding, understaffing, and underfinancing. To complicate matters further, the public, long accustomed to knowing little about mental retardation, often held inaccurate information, and there was a mystique about the retarded and other handicapping conditions involving feelings of hopelessness, repulsion, and fear. Gradually a change in attitude has been occurring as various significant efforts have been made to enlighten lay and professional people alike. But despite these efforts, the residential facilities of this country have languished. I would like to analyze briefly some reasons why public and, to some extent, private residential facilities throughout the country are so far behind.

In the mid-19th century, there was a wave of optimism about the care of the mentally retarded. The belief developed at that time that, through educational efforts, the retarded could be helped, and that most of them could be made self-sufficient citizens. When this concept, so noble in its beginning, appeared to have failed, decision-makers became committed to locating institutions away from the population centers of the state. This unfortunate decision seems to have been

motivated in part from the conviction that mentally retarded persons were best cared for in a more bucolic setting; in part out of fear that the retarded, being a scourge to society» should be removed as far from society as possible; and in part to satisfy demands to locate employment opportunities in underdeveloped areas in order to provide jobs and income to the surrounding communities.

Still later, the scourge notion grew, especially with the publication of poorly designed studies like that of the Kallikak family by Goddard (1912). The mentally retarded were soon to overpopulate our land, according to Goddard, and segregating them from society was the most important service to be rendered. As a consequence, further building programs for institutions were really a continuation of the out-of-sight, out-of-mind concept, and institutions for the retarded began to be considered as colonies where the undesirable members of society would be segregated and separated. Although this concept also proved to be fallacious, the country soon entered World War I, which was followed not long afterwards by the Great Depression, and these events permitted the mold to set, so that very little in the way of changes occurred for many years.

For whatever reason or combination of reasons, most of the nation's public residential facilities, and also many private ones, are located in out-of-the-way communities. Being so located has meant ever-increasing difficulty in obtaining qualified professional staff, who frequently prefer to live in larger communities. Similarly, the core of any institution, i.e., the ward or cottage personnel, have been increasingly difficult to recruit as the population has shifted from rural to metropolitan areas.

When citizens become concerned about an issue, such as where to locate a new highway or whether to build a new school, it has always been useful to be able to show these citizens, their legislators, and others in decision-making positions what the problem is all about by having ready access to a good existing example. This has been a problem for those trying to change the plight of the institutions, because it is doubtful whether there is a single exemplary model of care for the severely and profoundly retarded anywhere in this country.

To visit institutions, exemplary or otherwise, citizens in the past had to make a great effort, and then they often went only once. In part, this is so because, of the distance involved for many, and in part because they were repulsed by what they saw. Many legislators have appropriated large sums of money to support their public facilities, but have never visited a single institution for the retarded, either to see the need firsthand or to ascertain how the money was spent. There are physicians who refer families to these residential facilities but who have never seen the facility and do not know the professional personnel caring for the clients whom they refer. This

is an odd paradox since one cannot imagine a physician referring a patient to a hospital for an operation if he knew nothing about the place and people involved.

The underfinaneing of most public institutions is a tremendous problem. The 1966-67 per diem costs over the country (excepting Alaska) range from about \$3 to \$14. (U.S. Department of Health, Education, and Welfare.) In contrast, five of the largest zoos even a few years back spent an average of over \$7 for their large animals (see Blatt in this volume). While capital construction outlay and total operating budgets of institutions involve vast sums of money, budget increases, especially increases in per capita expenditures, have often been so token that very little help was given to the beleaguered institutional superintendent and his staff.

The underfinancing pertains to all aspects of residential care; it contributes, of course, to the understaffing. Salaries have often been at shockingly low levels. In many states, professional salaries have been at levels so low as to attract no one of competence, and the nonprofessional salaries for attendant personnel in many places have been below the national poverty level. Physical therapists are frequently lacking altogether. Speech therapists may consist only of untrained individuals. Occupational therapists may be totally unknown. While the children and adults may be kept clean, they often have no programs for daily living other than the meaningless blare of a television set or the completely empty, fenced-in court. Can anyone doubt that such practices have interfered severely with effective programming?

Many institutions have been so hard put to attract capable medical personnel that they have relied heavily on foreign-trained physicians, some of whom were unable to secure state licenses and hence were able to work only in a facility which could waive state requirements, such as is possible by a state facility. Unable to go elsewhere and being the only ones willing to accept the poor salaries, these men and women find themselves in virtual bondage, and the salary situation remains poor. Other institutions, even if large, have no full-time physician at all.

On the basis of some rough calculations it is estimated that about 30 percent of all budgeted positions in public residential facilities are now vacant (Noone, 1967). This can be explained partially by the fact that the attendant positions of many of our institutions are at the level designated by our government as poverty wages. Three thousand dollars a year will not provide personnel of high caliber! Since the cottage life and ward personnel constitute the backbone of any residential program, it should not be surprising to find that many habilitative programs are frequently seriously inadequate or lacking altogether.

The use of residents to perform work necessary to keep the institution running constitutes another problem which arises from underfinancing and which is sometimes referred to as "institutional peonage." Although it is highly desirable that residents be productively employed, continued and inappropriate retention of residents in work situations has often been the only way the daily work could get done. Some important services in the ward, infirmary, maintenance, laundry, and kitchen areas would collapse if it were not for continued reliance on resident help. In addition, absence of adequate community resources (e.g., workshops, group living facilities, community supervision) has meant that even if residents were to be released, there is often no place for them to live and no job for them to have. To habilitate the retarded person who has lived the better part of his life in an institution is most difficult, since he is ill-prepared to cope with the social requirements of a normal community.

The American Association on Mental Deficiency is currently evaluating our residential facilities. This is a voluntary process, and residential facilities are not obliged to submit. However, most of them do, and many are reporting that they are grossly overcrowded, being anywhere from 25 to 50 percent above their rated bed capacity (Blatt and Kaplan, 1967). Consequently, there are often large bleak wards where physically handicapped individuals are confined to bed, provided with minimal care, but given little in the way of stimulation to make their lives the least bit meaningful. Many will end their days in these drab surroundings. There is still an additional factor: increasingly, severely handicapped residents with multiple problems are being admitted because many such individuals, who would have died a generation ago, are now saved as a result of medical advances.

Recently, Blatt and Kaplan (1967) published a book entitled Christmas in Purgatory. In this book they indicated pictorially the deplorable state of some residential facilities. Although the authors were criticized by some, I believe that Blatt and Kaplan have performed a great and important service by pointing up this shocking problem. We all know of places where residents sit naked, surrounded by their excreta. I have seen a man without legs condemned to walk on his stumps because he once ran away from the institution, got lost, froze his legs and had to have them amputated. Everyone was reluctant to provide him with rehabilitative services for fear that there might be a repetition of this behavior, and, furthermore, his condition was perceived as a deserved punishment!

Overcrowding, understaffing, and underfinancing are three of the important issues related to public facilities, but there are others. One of these is obsolete architecture and design. Maintenance may have been so poor that lavatory and toilet facilities may be nonfunctioning, food preparation cannot be carried out in the desired sanitary fashion, and climate control may be so unequal to the task as to leave buildings either too hot or too cold.

Many Americans have the impression that poor residential facilities are something inevitable which must be endured, along with other evils of our times. Not so. One can visit several European countries, especially in Scandinavia, to find imaginative and unusual programs of care. Along with others, I have been impressed on my visits there to find many residential facilities which were located close to population centers. In Copenhagen I visited a residential facility (Children's Hospital at Vangede) which is in a suburban setting served by the city's rapid transit system. Many of these facilities have no more than 150 to 200 residents, and some are no larger than a large household. Staff-to-resident ratios are frequently 1:1, and the care provided is exemplary. In addition, the physical surroundings are pleasant, abounding in bright colors. Fixtures and furnishings are attractively designed and not the clumsy institutional or prison industry furniture often found in this country. Everything is meant to be attractive and to have appeal to those who must reside in such a facility.

The problems of our overcrowded institutions can only be solved by giving simultaneous attention to community resources. It has been pointed out on many occasions that the galaxy of services needed should include diagnostic centers, special education, day care, vocational training, sheltered workshops, residential schools, group living homes, etc. I would maintain that residential facilities will not be what we want them to be unless simultaneous efforts are made to rectify the situation in both the institution and the community.

As one major effort towards accomplishing the desired objectives, massive re-education is required. There is nothing to be gained by hiding the fact that our residential facilities are in a deplorable state, their buildings crumbling, the staff overworked, underpaid and often undertrained, and the programs providing only minimal care and habilitation. Each state must develop a greater public education effort to bring to the attention of the citizens this blot on our escutcheon. It should be our wish and intent to try to rehabilitate residents to the community, rather than to segregate them. This reorientation in thinking will require considerable effort as public officials, administrators of institutions, professional workers, and the lay public all come to understand that the handicapped and the retarded do not need to be moved aside, but rather should be a part of the ongoing community process.

Group homes, nursing homes, and respite centers which provide short-term residence in an effort to help families and to meet temporary needs should all be part of the services available in the community. Even severely retarded individuals with extensive physical handicaps can be handled in the community. Great Britain some years ago pioneered with the idea that the physically handicapped, as well as the person with other handicapping conditions, can and should be maintained in the community; but to do this, the concept was developed that even the most severe form of handicapping condition requiring prolonged nursing care could be cared for in the community as part of a regular pediatric unit.

Such services need not be separated, segregated and removed from society (Pediatric Society of the South East Metropolitan Region, 1962).

One might ask the question, Should not all such persons be maintained in the community? Why should they be removed? Should not society's aim be to try to help when mental retardation or physical handicap has occurred? One does not say to the parent of a child with leukemia that the child should be "put away," although everyone knows that the child will ultimately die, and understands the human tragedy which has occurred. Rather, all forces are mobilized to help and to sustain the child in the community even though he may need periodic hospitalizations. Surely the same approach should be used for the mentally retarded and the physically disabled.

In the easing of understaffing, two programs are worthy of note. The Foster Grandparent Program (under which the government pays retired citizens to engage in one-to-one work with retarded persons for a few hours a week) has been successful in helping to cope with the manpower problem. It meets the needs not only of handicapped persons but also of the elderly who are looking for a constructive role in our society where they can be of help and assistance and not be thought of as misfits, relegated to a shelf. The SWEAT (Student Work Experience and Training) program has been another successful device in attracting people, in this case youths, to mental retardation. Under this federally supported program, high school and college students are paid a stipend for working during a summer in a facility or service for the retarded. In many such programs conducted across the country the students have received didactic instruction along with the work experience. SWEAT has been one of the most imaginative as well as economical and apparently successful projects attracting young people to careers in this field. But much more is needed, and much greater effort will be required if the manpower problem is to be solved.

Throughout the Scandinavian countries, I have been greatly impressed by the numbers of young, eager, well-informed men and women one finds working with the retarded. At a school for cerebral palsied children in Gothenburg, Sweden, I had the opportunity of visiting one of the most delightful places to be seen anywhere. This happened to be a residential facility where things are so well developed that one could find a child who was ill (from some other cause) being read to rather than being left alone, as is so frequently the case in our country. A training program in Denmark for primary workers in mental retardation (equivalent to our attendants) is of considerable interest. The program is half theoretical and half practical. The students, many of them akin to school dropouts in this country, are recruited for such training, subsidized during it, and thereafter provided with good situations in which to work. A similar program has been in existence in at least one area in England,

While the turnover is fairly great among the young people in Scandinavia who are trained in these programs, there is another sidelight to all of this. Most of these young people will go on to be parents themselves, and having learned something about the handicapped as well as something about child development, they will be more understanding of the handicapped and also will be in a better position to manage their own families. At any rate, it can be noted that these ingenious training programs have come close to solving the personnel problem. This idea should be studied carefully by all of our states to see what can be adapted to the American scene.

In thinking about solutions for residential care, one certainly must give thought to architecture and size. Dr. Gunnar Dybwad has written much about the architectural barriers in residential facilities. He and others would point out that if existing buildings are to be modified in order to relieve overcrowding, a loss in bed space is inevitable. On the basis of 10 to 15 years of experience, the Scandinavian countries, again leaders in the remodeling of existing buildings, have pointed out that it is absolutely necessary to plan on reducing the number of beds by half in order to bring many old buildings up to modern standards.

The desirability of having large facilities of 1,000 or more is still controversial. Many of our facilities are of this size, or larger, and some more are now being constructed. The evidence is not convincing as to why large residential facilities need be built. The argument often runs that large facilities cost less to operate. I would suggest that this point has not been proved. Currently, the President's Committee on Mental Retardation is in the process of having a study conducted concerning what is known about costs of running large versus small facilities. There is preliminary evidence to suggest that small facilities of 150 to 250 can be constructed and operated at no more than the cost now being utilized in the larger residential facility, and perhaps even at less cost. It is even possible that the hostel concept of placing small groups of retardates into existing rented, leased, and purchased homes and facilities (rather than newly constructed ones) will prove the most economical alternative for many retardates needing residential care. Existing facilities are often cheaper than new construction, and rentals and leases preserve the flexibility of locating and using facilities as needed--a flexibility that is drastically reduced in new purpose-built construction. Cost analysis can be deceptive, however, if one is not comparing like commodities. The study will, I believe, shed some important light on the entire matter of cost accounting in the operation of these various facilities.

An additional point to be made about the size of an institution certainly relates to one's sense of human values. In today's world, where many of us become numbers on an IBM card, we feel great reluctance to bid farewell to the concept of a more individualistic approach to human services. Increasingly, people express preference for return to

small units and systems, whether in a university, a city, or a residential facility. These human values must not be permitted to be overshadowed by too much architectural efficiency and the engineering consideration of locating buildings at the point closest to the steam plant. Surely we have seen the problems of regimentation so as to be ever on guard in all sectors lest we increase or even perpetuate this problem.

I have not written much about which one can be happy. Individuals and groups concerned with the handicapped and retarded should make every effort to join hands with each other to see what can be done to improve this deplorable situation. I would suggest that the reorientation of the community will be the crucial factor. Facilities close to where people live should be the watchword,, At the same time, we must attend to the condition of our existing facilities, to improving the pay scale, to reducing the number of residents, and to restructuring the mission of residential facilities in ways which will return residents to the community.

The Rationale of the Book

The President's Committee on Mental Retardation has been deeply concerned about the issues sketched above. The Subcommittee on the State of the Nation was instructed to give serious study to this problem in 1967/68. As chairman of the Subcommittee, I have invited several American and European leaders known for imaginative conceptualization, planning, construction, or administration of residential and other services to take a thoughtful look at the plight of our nation's residential programs and facilities for the retarded, and to put their thoughts on paper. No attempt was made to develop an exhaustive handbook on residential care, but to examine the present system and to delineate some alternatives and courses for action.

While the focus of this effort was to be on residential services in the United States, it became obvious that one cannot look at the residential problem without addressing oneself broadly to all aspects of services to the retarded, and even to human services more generally; and that in examining our problems, we can both learn from and perhaps contribute to the experiences of our colleagues in other countries.

The compendium of papers was intended to serve as a resource to the Subcommittee, and ultimately the total Committee, in formulating recommendations to the President and the nation. However, it was felt that the thinking of the authors should also be brought before a wider audience, and that this compendium that has contributed so much to the deliberations of the President's Committee should be published. Specifically, an attempt was made to structure the contributions to this volume in such a way as to make them useful not only to specialists in the field but also to nonspecialists who can or must make decisions relevant to the future of the field. Among such individuals might be

legislators, officials at various levels of local, state, and federal government, and parent leaders. Last but not least, it was hoped that part or all of the book could be useful to students of mental retardation.

The rationale for the composition of the book deserves some discussion. The concept of "models" underlies the entire book and ties its various elements together. First, we attempted to provide an understanding of the current situation, i.e., the current models, and the first four parts (five chapters) of the book are devoted to this. The next three parts (eleven chapters) introduce suggestions and examples for constructive change (new models). The last part attempts to digest and integrate all of the earlier chapters and to translate them into specific recommendations for action. Appendices were added to a number of chapters. These appendices contain material that would disrupt the continuity and balance of a chapter, but which provide documentation or elaboration that might be of high interest to some users of the book. A more detailed discussion of this progression of the book follows below.

In Part 2, immediately following this chapter, Butterfield presents an array of basic facts about public institutions for the retarded in the United States. The intent of this chapter is to inform the nonspecialist and foreign reader of some quantitative aspects of the problem and to serve as a reference source to others. It should be noted that other chapters frequently make reference to the type of data presented by Butterfield.

Part 3 contains accounts of personal reactions to visits of rather typical state institutions for the retarded. Blatt's chapter is related to a book (Blatt and Kaplan, 1967), repeatedly referred to by other authors in the volume, and to an article based on this book and published in Look. Blatt depicts realities which many of us would prefer to deny, but which can only be called inexcusable for a wealthy nation such as ours. Indeed, such conditions are a disgrace to the nation, as should be clear from the next chapter by Nirje.

Nirje brings a perspective to bear which can be very valuable to us. Highly knowledgeable of mental retardation services across the world, he visited the United States with few preconceived ideas of what he might see, and--what is particularly painful to us--he had no axe to grind or vested interests to represent; thus, only someone with a strong vested interest himself could dismiss his judgment of our institutions lightly.

To understand the present and minimize errors in the future, one must know and understand the past. In Part 4, Wolfensberger attempts to interpret the history of United States institutions for the retarded in the light of certain theoretical constructs that have gained prominence in recent sociological thinking. A construct of

particular strength in Wolfensberger's analysis is role and role perception. According to this analysis, our institutions generally function as if their retarded residents were perceived either as a social menace or as subhuman organisms, and institutional reform will depend more on changes in ideology than on vast monetary expenditures.

Wolfensberger's documentation of various trends may appear to be excessive, but was retained because of historical circumstances: in challenging some widely accepted views, and in attempting the first major reinterpretation of the development of retardation institutions, it was felt necessary to provide solid substantiation. Otherwise, his interpretations might be dismissed as ill-founded, highly personalized hypotheses.

The first five chapters, Parts 1-4, essentially represent attempts to define and understand a problem, and to set the stage for thoughts about constructive action. In Part 5, various authors-present service concepts which have either already been tried and found highly useful, or which, if untried, are relatively logical and feasible innovations.

In the first chapter of Part 5, Blatt presents some proposals on how to improve institutions if we must have them. These proposals, of course, stem from the observations he discussed in Chapter 3.

In the next chapter, Nirje, too, puts the observations he recorded earlier (in Chapter 4) into perspective. He presents the theoretical construct of "normalization" which underlies much of the Scandinavian legal and service structure in mental retardation. This construct has never been fully presented in the American mental retardation literature, but it is of such power and universality as to provide a potential basis for legal and service structures anywhere. Indeed, the editors of this book view the normalization principle as perhaps the single most important concept that has emerged in this compendium,,

Blatt presented specific measures for institutional reform, and Nirje a broad theoretical framework for retardation services generally. At this point, Tizard and Dunn present chapters on practical, even administrative, aspects of service development and structure. Tizard treats the problem of determination of service needs, balance of service provisions, and the place of residential services within the service continuum. In a sense, he brings close to us the service concepts which were advocated in the 1962 Report by the President's Panel on Mental Retardation, but which so far have been implemented in only very few instances in this country, and even then only partially so.

It is quite likely that even without any further theoretical or empirical elaboration there would be a trend toward dispersement of

residential centers. However, Dunn warns that while disbursement is highly desirable, it may not be enough. Both for programming and staffing reasons, he urges that residential facilities be not only small and dispersed, but that specific professional disciplines should operate different facilities according to their own service models, specializing upon the management of relatively homogeneous groups of residents.

A theme brought out again and again in this book is the need to include, view, and discuss residential facilities as only one component of a continuum of services. Nothing is as convincing of the viability of such a broad service system as visiting and seeing one in operation. Since this book cannot provide an actual visit, we decided to do the next best thing and present detailed descriptions of four model service systems. To serve as a model, the following requirements had to be met:

1. A model had to consist of a clearly circumscribed, currently functioning, entity, so that it could be unequivocally identified, described, and seen in operation by those desirous of visiting an operating exemplary system.
2. In order to demonstrate the feasibility of continuity of services, the model had to contain a range of services of which residential facilities were one part.
3. In order to be instructive in regard to administrative and planning aspects, the model had to be in a dynamic state of evolution according to a well-conceptionalized and formally defined (written) planning scheme.
4. Since services to the retarded are increasingly perceived as a right, and since services defined as legally rightful tend to be operated or at least regulated by governmental units, a model had to be operated or regulated under public auspices in order to be maximally instructive.
5. Long-term planning is not very feasible or meaningful unless the plan is for a well-defined geopolitical area. Because of this consideration, as well as the requirements of items 1 and 4 above, a model was required to be associated with a well-defined geopolitical unit.
6. Someone intimately familiar with a potential model service system had to be willing and capable of rendering a global, balanced, well-written description of it.

It was felt that these requirements would not only yield the most instructive examples, but that these characteristics would be those held by most service systems considered most exemplary by leaders in the field. It was with such leaders around the world that

we consulted in order to identify service systems that would meet our criteria and be considered exemplary. To our surprise, very few systems were considered exemplary by these experts, and not all of these met the requirements. In the United States, despite extensive consultation, we would identify only one service system that came even close to satisfying the criteria. From other countries, three models emerged as suitable. Thus, a total of four model service programs were finally identified, described on paper, and presented in Part 6.

The head of the Danish National Mental Retardation Service, Bank-Mikkelsen, describes the first model. This model involves an urban-metropolitan area, i.e., Copenhagen, which is one of 11 service regions of Denmark. Of special interest here is the extensive application of normalization principles, as described by Nirje, to a service system. Similarly, this principle is expressed in Grunewald's description of MalmBhus County in Sweden, a geopolitical area which, in contrast to Copenhagen, is mostly rural in nature. These two chapters, together with material presented by Nirje in Chapter 7, provide a great deal of information on the legislative underpinnings of services of two countries considered exemplary in many aspects of mental retardation provisions.

In Chapter 12, Norris describes the services of Essex County in Britain. This county is widely regarded as a model in Britain. Also, while Scandinavia appears to lead in the elaboration of residential provisions, some counties in Britain are more advanced in developmental services for severely retarded young children and in vocational services for retarded adults. This type of emphasis clearly emerges in the Essex system, especially in relation to the large number of sheltered workshop places provided or planned by that system.

Finally, the service system in the State of Connecticut is described. In including this description by Klaber, it is not intended to present the Connecticut model as an ideal or even desirable model for all states and areas. However, it is intended to show how an attitude of dissatisfaction, combined with relatively consistent concepts, has led to popular acceptance of a new service system that is vastly preferable to the old one, and that is superior to most systems now existing in the United States.

Part 7 contains three chapters which, in some ways, are similar to those contained in Part 5, since they present service-related issues and propose new solutions. However, these three chapters are presented separately because they either go far beyond the thinking of Part 5, or because the models in Part 6 do not exemplify the content of these three chapters.

In the first chapter of Part 7, Sarason makes a number of critical points. One of these is the importance of viewing residential facilities as human service settings generally, all subject to similar social

processes, dynamics, and trends. Secondly, those in the human service area will fail to understand and control events unless they view the operation of their settings from a larger social system viewpoint, rather than the narrow, individual-oriented clinical perspective of traditional service agencies. Finally, Sarason, points to the importance of consciously conceptualizing an ideology and a concomitant set of general practices from the very inception of a setting, and letting these rule the specifics of operation rather than the reverse.

The next two chapters contain service conceptualizations which might be interpreted as being "typically American." Cooke proposes an extension of Medicare principles and legislation to permit public moneys to be used to pay for private residential services selected by the parents. He feels that such an approach would quickly result in the development of numerous small, dispersed, residential homes; that presently unutilized manpower would come forth to serve in these facilities; and that these facilities, being of high quality since they would have to meet stringent requirements, would "drive out" big and poor institutions.

In the third chapter of Part 7, Wolfensberger presents what appears to be the most radical innovation suggested in this book: a human service system based on a cost-benefit rationale. He suggests that residential services in retardation should be considered not only an integral part of a wider retardation service system but part of a broad system of human services generally. The publicly supported part of this system, he feels, should be reorganized so as to reduce the autonomy of service agencies, and decision-making regarding specific service allocations should be based on considerations of how service benefits can be maximized for the largest number of citizens, given the limited resources available at any one point in time. Perhaps this proposal is Utopian--perhaps it is prophetic. Indeed, the cost-benefit concept is gaining in ascendancy in industry, Congress, and elsewhere, and the question of national priorities that is now widely discussed for the first time is closely bound up with cost-benefit notions.

The final part and chapter of this monograph is written by Dybwad, one of the most prominent thinkers about mental retardation services in this country, and perhaps the world. In this chapter, he attempts to interpret and place into perspective the contributions of the other authors. Most importantly, from the vast amount of problems, issues, examples, and solutions discussed, he attempts to isolate implications on various levels of action and implementation. From the material presented in the preceding parts of the book, he attempts to translate theoretical notions into concrete proposals, and judge concrete measures as to their feasibility and priority in the America of today.

The editors are most grateful to all of the contributors of this book. For each contributor, it meant working against a deadline, but all were willing to take time from exceedingly busy schedules to add their thoughts to this volume.

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