International League of Societies for the Mentally Handicapped
Ligue Internationale des Associations d'Aide aux Handicapes Mentaux
Internationale Liga von Vereinigungen zugunsten geistig Behinderter
Liga Internacional de Asociaciones Protectoras de Deficientes Mentales

RESIDENTIAL CARE FOR THE MENTALLY HANDICAPPED

CONCLUSIONS Symposium Frankfort,

14-18 September, 1969

Residential Care for the Mentally Handicapped

Symposium Frankfurt 14—18 September, 1969

Conclusions

Sponsors: Federal Ministry of Health, Youth and Family, Bonn
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INTERNATIONAL LEAGUE OF SOCIETIES FOR THE MENTALLY HANDICAPPED

The League was brought into being in World Mental Health Year 1960, by representatives of parents organizations, professional groups and by individuals anxious to advance the interests of the mentally handicapped without regard to nationality, race or creed.

Through the creation of a common bond of understanding between parents and others interested in the problems of the mentally handicapped, the League hopes to secure on their behalf from all possible sources the provision of efficient remedial, residential, educational, training, employment and welfare services.

The League seeks to realise its objects by:

a) the interchange of experts and information, on the developing services for mentally handicapped;
b) the exchange of workers in the field of mental handicap between one country and another;
c) the comparative study of legislation in member countries and beyond, concerning the mentally handicapped and the promotion and imple mentation of same in their favour.

The League is recognized by UNESCO.

The League welcomes applications for membership, which is open to all parent and other national organizations working primarily in the interest of the mentally handicapped.

Congresses were held in

1961 London — The Hague (Education, Training and Employment) 1963 Brussels (Education and Social Integration) 1966 Paris (Stress on Families) 1968 Jerusalem (From Charity to Rights).

Symposia were held in

1966 Frankfurt (Sheltered Employment)
1967 Strasbourg (Organisational Development)
1967 Stockholm (Legislative Aspects)
1968 Ostend (Education)
1969 San Sebastian (Guardianship)
1969 Frankfurt (Residential Care).

Reports can be obtained from the secretariat of the International League: 12, rue Forestiere, B-1050 Bruxelles.

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FOREWORD

Residential care historically may be considered as one of the first efforts to find a satisfactory solution for the manifold problem mental retardation causes to the persons inflicted, to their families and to the society. In the last decades in many countries overall-programs of help have been developed, especially by societies for the mentally handicapped. These community-services aim to their utmost possibility to integrate the mentally handicapped into today's society. For a number of mentally handicapped, however, residential care, at least for shorter or longer periods, will always be necessary and desirable. Unsatisfactory legal and financial conditions, forthcoming of society's lacking interest in the problem of mentally handicapped, in the past often prevented a satisfactory development of residential services. Nowadays efforts of professionals in the field of residential care and parents' organizations in many countries have woken increased interest in modifying existing practices of such services.

This Frankfurt Symposium was organized to discuss on international level current trends and achievements in this field which might contribute to further the future development of such services.

Working papers on basic subjects which had been sent in advance to all participants were discussed in half-day sessions at which one of the other experts was acting as chairman.

Simultaneous translation in English, French and German enabled the participants to speak in a language they mastered, which is a necessary condition to obtain optimal results from such an international interchange of information. It is to be hoped that the conclusions of this Symposium may be of help in planning new or modifying existing residential services and that the fruitful discussion started in Frankfurt will be continued according to the increasing need of information on the further development of this important section of help.

Tom Mutters Chairman of
the Symposium Vice-President
of the ILSMH

INTRODUCTION

The complex issues of furnishing residential services for retarded children and adults were the focus for discussion by 47 representatives from 13 National Member Societies of the International League of Societies for the Mentally Handicapped, meeting for 4 days during September 1969, in Frankfurt Germany.

Seven working papers were prepared by invited experts and distributed to all participants prior to the Symposium (these papers are available on request from the League). These papers became the basis for the discussions. Discussion of each paper was summarized by a small team of participants, and most summaries were then presented to the rest of the participants for comment and modification. The Conclusions were prepared from the working papers and discussion summaries by a small editorial committee selected by the participants.

Although it became apparent, as the discussions proceeded, that the participants brought divergent positions to the Symposium, basic areas of concensus gradually emerged. The Conclusions primarily summarize these areas of general agreement, while occasionally alluding to issues which, though prominent, were not completely resolved.

These Conclusions are not presented as the final word regarding residential services, but rather as a condensation of current thinking in this rapidly evolving area. Too often today's progressive pronouncements become tomorrow's obstacles to innovation. Hopefully the Conclusions of the Frankfurt Symposium will never be used as immutable principles or self-evident verities; they are hypotheses to be tested by time.

DEFINING CONCEPTS

Semantic and linguistic problems often interfere with effective international communication. It is vital, therefore, to clarify definitions of basic concepts.

Mental Retardation:

Mental retardation can be broadly defined as a form of deviancy, characterized by difficulty in complying with cultural values regarding intellectual and social behaviour.

Specific definitions of mental retardation differ from country to country. For example, the term "severe retardation" as used in England and Sweden is roughly the equivalent of "moderate retardation" as used in the United States. Such differences in meaning of terms are likely to lead to erroneous conclusions regarding programs in different countries.

For the purpose of this Symposium, mental retardation is defined to include the four levels described by the American Association on Mental Deficiency: mild, moderate, severe and profound retardation. This definition is based on multiple criteria, including measured intelligence (usually quantified as an Intelligence Quotient), adaptive behaviour level (sometimes quantified as a Social Quotient), and medical classification.

Residential Services:

The term "residential services" is used generally to include all forms of sheltered living arrangements in which retarded children or adults live away from their natural family. "Institutional services" is sometimes used to refer to a specific type of living arrangement in which the residents are served on a twenty-four-hour-a-day basis.

A wide variety of residential services are recognized, differing somewhat in different countries. In Sweden, for instance, the following four types of facilities for retarded adults have been described: (1) the "special hospital," (2) the "central institution," (3) the "local institution," and (4) the "boarding home and hostel." In addition, two types of facilities for children have been developed. Other countries have slightly different types of facilities.

Principle of Normalization:

Although the Principle of Normalization is now widely recognized and accepted as an important approach to residential services for the retarded, it is still often misunderstood. As defined by Bengt Nirje, the Principle refers to "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society." The Principle is applicable to a wide range of situations and to all levels of retardation. It essentially refers to approaching the retarded as much as possible as if they were normal.

The Normalization Principle should not be misconstrued as being synonymous with the concept of "maximizing the human qualities" of the retarded, which refers to a goal rather than to an approach. In this context, "human qualities" refers to specific behaviour which is considered culturally desirable by the particular culture of which the retarded is a member. Application of the Principle of Normalization is usually assumed to maximize the human qualities of the retarded, although it is conceivable that for some retarded individuals other principles may be equally or more effective in reaching this goal.

Obviously what is considered ,,human" behaviour is culturally defined, differing from culture to culture. Likewise what is considered "normalizing" is defined by the practices and "conditions of everyday life" of particular cultures. it can be assumed, however, that certain basic principles — such as treating the retarded with dignity — transcend specific cultures and should underlie practices in all countries.

All retarded children and adults are basically human beings, who must be treated with dignity and guaranteed fundamental human rights.

Efforts must be directed at eradicating "dehumanizing" conditions which still exist in some residential facilities. Conditions may be considered as dehumanizing to the degree to which they foster behaviour which departs from the cultural norm. Such conditions frequently violate the dignity of the retarded residents.

Retarded individuals should be treated so as to promote emotional maturity. They should not be treated as children throughout their lifetime, less childishness become fixed rather than replaced by adult patterns of behaviour.

Most mental retardation programs have paid little attention to the goals of retarded persons themselves, and typically few opportunities are provided for encouraging them to participate in decision-making or goal setting. Yet most retarded men and women are capable of setting life goals and communicating their desires and aspirations.

Even non-verbal retarded children and profoundly retarded adults can often select among alternatives if given the opportunity.

Fostering happiness of retarded children and adults is a desirable goal, just as is fostering happiness of non-retarded individuals. Yet as is true with the non-retarded, fostering happiness of the retarded should be secondary to the goal of developing their human qualities. Children of normal intelligence are not allowed to give free vent to their hedonistic demands, since they are expected to adopt culturally sanctioned behaviours; the same principle should apply to retarded children. Programs which are aimed simply at generating happiness in retarded individuals are failing to meet the more basic goal of maximizing their human qualities.

Retarded children and adults in general experience happiness just as their normal counterparts. Usually they are made happy by the same things and situations which generate pleasure in the non retarded, so they should be encouraged, whenever possible, to share such situations with the non-retarded.

The Principle of Normalization is a sound basis for programming, which, by paralleling the normal patterns of the culture and drawing the retarded into the mainstream of society, aims at maximizing his human qualities, as defined by his particular culture. Retarded children and adults should, therefore, be helped to live as normal a life as possible. The structuring of routines, the "form of life" and the nature of the physical environment should approximate the normal cultural pattern as much as possible.

The most appropriate model of mental retardation is a developmental model, according to which retarded children and adults are considered capable of growth, learning and development. Each individual has potentials for some progress, no matter how severely impaired he might be.

The basic goal of programming for retarded individuals consists of maximizing their human qualities, and as such is identical with the goal of educating and socializing normal children and young adults. The adequacy of programs as well as of physical environments can be evaluated in terms of the degree to which they fulfill this goal.

In general this goal is best reached by applying the Principle of Normalization and including the retarded within the mainstream of society or replicating the patterns and physical characteristics of the prevailing culture when it is necessary to withdraw the retarded individual from society for a greater or lesser time period. However, to the extent that departure from cultural norms in either programming or physical environment enhances the retardate's human qualities, such departures do not violate the Principle of Normalization, although they might lead to practices or physical settings which differ markedly from the cultural norm.

The goal of programming for adjustment to community living is desirable and appropriate for most retarded individuals, yet it may be unrealistic and need to be modified for some seriously handicapped individuals, who may come closer to maximizing their human qualities by adapting to a specialized environment. Even profoundly retarded persons who may remain institutionalized should be stimulated to reach their optimal level of functioning.

Specific program goals must be tailored to meet the needs of each individual, and they will differ for different degrees of impairment. The most feasible and humane approach, in view of current limitations of knowledge, is to assume that all retarded have the potential for discharge from an institution until their response to programs clearly reveals the inappropriateness of this goal.

ADMINISTRATION OF RESIDENTIAL SERVICES

Residential services should be based on a developmental model of mental retardation, fostering optimum humanization of each resident.

Mental retardation should not be approached as an illness or as a lifelong, unalterable state in need of treatment and protection. These approaches generate attitudes of overprotection and helplessness in staff and parents resulting in dependency, passivity and lowered self-esteem in the retarded.

The great majority of the retarded are ordinary people with an ordinary person's needs. In addition, they have particular specialized needs attributable to their handicap. Residential services should be based on the concept of serving human beings with human needs and additional special needs.

The hospital model is inappropriate for residential services for most retarded residents. Specialized hospital facilities may be incorporated into a system of delivery to serve those suffering from illness or requiring intense medical care. This group should include only a small fraction of those in need of residential services at any one time. The general nursing staff of residential services should be independent of medical administration, thereby fostering a progressive elimination of all traces of institutionalization or hospitalization.

It is now widely agreed that services to the retarded must be multidisciplinary. Special training in a specific profession is in no way uniquely qualifying for administration of mental retardation services.

Management monopolies based on pseudo-logic by which particular professions have, in the past, assumed administrative control of retardation programs are not in keeping with current understanding of mental retardation or with the multidisciplinary approach. Such monopolies should be replaced by management models based on a multidisciplinary team concept.

Administrators of retardation residential services should be selected on the basis of: (1) expertise in the general area of mental retardation, (2) administrative skills, and (3) appropriate personality qualities, including leadership attributes. The administrators of residential services for the retarded should be assisted by a multidisciplinary team. The central authorities in control of retardation services must include key administrators from all relevant state or national agencies, such as the Ministries of Social Welfare, Education, and Health.

Administration of residential services should include strategies for involving parents and retarded persons themselves in decision-making which will affect them.

THE CONTINUUM OF SERVICES

Retarded persons should have the same rights and benefits enjoyed by other citizens. They should, consequently, be entitled to special services for their particular handicap, just as other citizens are entitled to services for their illnesses, handicaps and other special needs.

Whenever possible the retarded should be integrated into society, to participate as fully as possible in the activities of the society to which they belong. Generic services should serve them whenever practical, so that specialized services whould be needed only in exceptional cases to meet special needs. For example, evaluation of individuals suspected of mental retardation requires specialization which may not be available except in specialized centers or even in residential facilities.

Retarded persons and their families are entitled to services within easy distance of their homes. Consequently, development of regional or district services is desirable.

Each region should include a full complement of services readily available to the retarded of the region and their families. These services should be administered and coordinated to provide maximum flexibility and ease of transfer from one service to another, since placement of a child or adult is as a general rule not permanent, but is frequently subject to reconsideration.

The retarded person should remain a member of his community, even if dependent on others. Although there are some who may be unable to live in society, the most severely handicapped should not be the basic denominator for limiting ways of helping the majority. The concept of lifelong institutionalization is inappropriate for the great majority of retarded persons.

Central residential facilities remain an indispensable component of the continuum of services. These facilities should not be located away from communities, but in the midst of communities, designed to blend harmoniously with the surrounding neighborhood.

Since residence in a centralized or relatively self-contained facility is less desirable than more active participation in society, adequate alternative services — including community-based small residential facilities — must be readily available.

The trend is away from boarding schools where children live and are taught in the same building or institution. Instead school homes, often used only during the week, furnish residential services while children attend integrated community-based special classes.

Self-contained living units should be replaced by a full range of services, of which residences are only one aspect. Programming must include the three dimensions of living, working and/or schooling, and recreation.

Residential and day-center services should function in partnership, complimenting each other's specialized functions. Day-centers — as preventive services — should be made available as early as possible, particularly before seven years of age.

Any service for the retarded should always have a back-up service to which the retarded can be referred for more specialized care, until the level of maximum intensive care is reached. The flow of residents should be reversible, so that they can easily return from intensive care facilities to central or local residential facilities.

EVALUATING THE INDIVIDUAL

Evaluation of children and adults suspected of mental retardation must be comprehensive and must include determination of functional level and individual needs. Intelligence tests supply only limited information and are, in themselves, an inadequate basis for programming.

Labeling individuals has the potential danger of leading to self-fulfilling prophesies, resulting — in part — from limiting opportunities for education and training. Hence terms such as "bed-fast", "tube-feeder", and "sub-trainable" are dangerous if used as prognostic constructs.

Our current state of knowledge does not allow accurate prediction of which children will remain institutionalized, so that all must have the same chance for independent living.

Criteria for institutionalization will differ from society to society, since tolerance for deviancy is culturally determined.

Programming for each individual retarded child or adult should be based on an analysis of his unique needs at any given time rather than on a static diagnosis. Since these needs change with time, it follows that periodic re-evaluations are essential.

PROGRAMMING FOR THE INDIVIDUAL

Programs should be designed to offer all retarded children and adults maximum opportunity to optimize their human qualities. For most retarded this will mean participation in society's main stream, but for some it will mean functioning at their optimum level within the specialized environment of a residential facility.

Program planning for the retarded individual should be based on analysis of his unique needs at any given time rather than on a static diagnosis. Regular reassessment of residents is needed to periodically realign programs to meet changing needs.

Parents should be involved in close cooperation with staff regarding details of programming for their retarded children.

Retarded residents should not be used as part of a residential facility's work-force, unless they are hired as regular members of the staff and enjoy all benefits of regular staff. This principle does not negate the value of assignment to work stations as part of specific vocational training programs, provided that such trainees are in no way used to reduce the facility's paid work-force. Likewise performance of chores related to daily living, such as keeping one's room cleaned or making one's bed, is a valid aspect of the normalization process.

SIZE OF RESIDENTIAL FACILITIES

The specific size of a residential facility will differ with the characteristics of the cultural matrix within which it is located. It must be recognized, however, that increasing size tends to foster self-containment and separation from the remainder of the community. Although large institutions are not necessarily closed systems, there is increasing danger of this as size increases.

Institution size and design should harmonize with housing in the neighboring community. The number of residents should not exceed the number that can be assimilated by the general community services.

The recommended maximum size of residential facilities differs. Denmark, for example, recommends a maximum of 300 children and 300 adults, either in separate or combined facilities. Sweden advocates "central institutions" of at least 100 and no more than 300. In the United States, there is some agreement that facilities should not exceed 1000, and many, including the President's Committee on Mental Retardation, consider 500 the maximum size.

Large multidisciplinary institutions tend to develop highly specialized services which duplicate those already available in the community, leading to isolation.

Large facilities can be reduced in size by decreasing the size of living groups, increasing staff size, dispersing services into surrounding communities, developing alternative small residential services, and careful screening of admissions based on comprehensive evaluations.

An initial step toward applying the Principle of Normalization to existing large institutions would consist of developing small living and programming units within the facility.

Small facilities, are, in general, better suited to the needs of retarded individuals than large facilities. The principal advantages of small facilities include maintaining geographic proximity to families, facilitating interaction with all aspects of community life, and decreasing the perceived deviancy of the retarded by himself and by the rest of the community. Small facilities are more flexible so that program changes can more easily reflect changing needs of the residents.

Smallness of size is no guarantee against separation and segregation of a facility from society or dehumanization of its residents.

Specialized facilities have many obvious advantages, such as developing highly qualified professional staffs and intense programs designed to meet the unique needs of selected groups of residents. Such facilities must guard against self-containment, however, less they generate self-fulfilling prophesies which would impede maximum development of their residents.

SIZE OF LIVING GROUPS

Grouping retarded children and adults into small groups and housing them in small living units are essential to maximizing their development. The specific size of groups may differ, but should probably not exceed eight. Denmark, for example, recommends houses for twelve to sixteen children, subdivided into groups of four to six. Sweden now builds units housing a maximum of twelve adults or eight to ten children. Small groupings *per se*, however, do not guarantee adequate residential services. The skills and attitudes of staff are a key factor in humanizing living situations.

Separation of sleeping from activity areas and assuring the opportunity for a personal private area are basic to implementation of the Principle of Normalization. Likewise institutions should be split into an educational-vocational-therapeutic sector and a separate residential sector, consisting of several small living units.

Residents should be grouped on the basis of definite criteria. Level of functioning and — where required — physical condition are valid basis for grouping. All facilities should be designed to accommodate the physically handicapped, however, to avoid their segregation

if not required by the need for specialized staff. Grouping on the basis of age is generally desirable. Denmark, for example, recommends separation into units for children, youth, adults, and old people.

Combining both sexes is desirable in some living units, depending on age and social maturity of the residents and cultural consideration of the community of which the facility is a part.

The desirability of separating adults from children remains a debatable issue. One point of view advocates that children should live in separate living units from adults. The needs of the two groups differ so that they require different physical environments, programs, and professional expertise. The process of becoming an adult requires a supportive series of changes in life style which mark progress to adulthood, and transfer from children to adult units facilitates this transition. Retarded adults resent being housed with children, and their wishes should be respected. Furthermore, parents have different expectations and attitudes when adults live with children than when the age groups are separated.

According to a second point of view, however, heterogeneous age grouping is desirable because it approximates the 'normal family situation, in which persons of different age and sex live together in a small intimate group. Dichotomizing residents on the basis of age increases the ..generation gap" and impedes the development of identification with adult roles.

THE PHYSICAL ENVIRONMENT

The effectiveness of the physical environment should be evaluated on the basis of the degree to which it achieves the goal of maximizing the residents' human qualities.

Congruence between the physical environment of the residential unit and residences in the community being served will tend to optimize the human qualities of the retarded residents. The Principle of Normalization suggests a "home-like" environment whenever possible, including cottages or "small houses", home-like furnishings, easy access to the out-of-doors, opportunity for privacy and personal property, and maximum freedom for each resident. The environment should differ with the age of the residents.

Consideration must be given to the territorial needs of the residents, which increases with adolescence and adulthood. Spaces should be provided to allow some activities to be performed in private, others in small groups, and others in large groups. Collective facilities designed for functions performed in privacy in normal society, such as toilets and bedrooms, are undesirable.

In general, buildings should be as similar as possible to those for normal people. There may be instances, however, in which specialized environmental modifications will enhance the retardates' human qualities. To the extent that they achieve this goal, such modifications are in harmony with the Principle of Normalization, even though they might result in physical environments that differ from the cultural norm.

Departure from homelike conditions may be justified in that they (1) offer the resident maximum control over his environment so as to allow him as much option for choice as possible or (2) relieve staff of certain routine drudgery so as to allow maximum attention to meeting the residents' emotional and social needs.

Some buildings may need to be specialized with regard to safety and manageability, including grade access, broad doors, ramps, round edges, soft floors and walls, security glass, mechanic ventilation, special lavatories, and sound-reduction. Such modifications should be determined by the special needs of the residents, such as hyper and hypoactivity, distorted perception, or sensory impairment.

The physically disabled, except in cases of gross handicap requiring specialized staff and/or equipment should be grouped according to criteria other than their physical handicap. The environment should not be structured to segregate them in separate units.

Some experts advocate a "simplified" environment, including simplified physical structures and a "slow, calming pace of life". This type of environment may benefit some residents by making it easier for them to use all facilities, contributing to their development and feeling of security. This concept must not be misconstrued to imply a dearth of stimulation or an unrealistic "sheltered paradise" which might impede transfer to the community.

The architect should be involved as a member of the multidisciplinary team in planning new construction, long before site selection. He should participate in high level planning and decision making. Likewise staff who are to use the facility should be involved in its planning.

The need for normality should guide the design of facilities, and when departure from the normal home-like environment is needed to meet special needs, the whole team — and particularly the architect — must clearly understand why.

Architectural planning should be based on a detailed functional program, specifying such items as staff functions, resident needs and activities, types of groupings, program goals, and relationship to other community services. It is helpful to consider environmental design in terms of such basic activities as sleeping, eating and recreation.

THE ROLE OF PARENTS

Parents should play an important role in residential services for the retarded. They can work most effectively with residential centers by uniting into organizations. Such associations can consider issues with greater objectivity than individual parents.

Parent associations should interact with professional staff at four levels: national, state or regional, institutional, and individual living unit. They should be involved in at least three basic types of functions relative to residential services:

(1) Associations should be involved in general policy making, including representation in executive or advisory bodies, both at the state and institutional level. The effectiveness of associations in policy making is in direct relationship to the degree of respect and visibility of the national association.

(2) Associations should be involved in management at the state and institutional level through appropriate representation on boards and advisory bodies. In general, parents should not be responsible for the details of operation, since this is a professional responsibility and parents may lack the necessary objectivity and expertise.

(3) Associations should participate in day-to-day activities, based on a climate of confidence between parents and personal. This climate is easier to develop with parent associations than through individual

parents. The parents' role as controllers and collaborators is most appropriate in relation to individual residential facilities. An important function of parent groups should be to evaluate the humane treatment of retarded children and adults and to secure their human rights.

The relationship between parent and child residing in a residential center should remain as congruent as possible with the normal cultural pattern. Parents should be included in all decisions affecting the future of their retarded child. The optimal development of the child may not always harmonize with parental wishes. In some cases parents' egocentric needs may overshadow their child's developmental needs.

Residential staff often still resist personal involvement of parents in institutional programs. Parents are still often mishandled by professionals, who tend to exclude parents from decision-making as full team members. Many residential facilities fail to keep in touch with parents and families. On the other hand, a substantial number of parents do not maintain regular contact with their institutionalized children. Geographic remoteness of many facilities serves as a serious obstacle to family contacts and involvement.

The functions of individual parents should include the following:

(1) Maintenance of consistent contact with their own child.

(2) Support and encouragement to the professional staff at all levels who are involved in the case of their child.

(3) Stimulation and coordination of efforts by other voluntary organizations on behalf of the institution.

(4) Interpretation of the institution's functions, programs and needs to the rest of the community.

(5) Strengthening of relationships between the institution and the rest of the community.

THE ROLE OF VOLUNTEERS

Volunteers can contribute very significantly to residential programs for the retarded. Among a wide variety of functions, the following are some of the most important:

(1) Fostering rapprochement between residential facilities and the remainder of the community, thereby minimizing the isolation in which many institutions have operated.

(2) Providing additional amenities and facilities, otherwise un available to retarded residents.

(3) Contributing to the development of the human qualities of the retarded by providing increased opportunities for meaningful inter personal interactions.

Volunteer functions must be of genuine interest; too often volunteers have been assigned meaningless "busy work". Volunteers should be expected to perform at a high level of proficiency. The concept of the "volunteer" is in no way synonymous with "amateurish". Likewise volunteers can respect professional confidentiality as well as staff, if properly indoctrinated.

Volunteers performing services in residential facilities should not replace staff or be used to alleviate manpower shortages. Quite on the contrary, good volunteer programs require availability of competent staff. Volunteers are most efficient in the best facilities, where the ratio of personnel to residents is already high.

Staff, including top level administration, must be receptive to volunteers if programs are to succeed. Volunteer programs require investment of staff time and access to adequate facilities. Staff must be prepared and oriented to effectively work with volunteers. The volunteer's relation to a retarded resident always involves at least one staff member as well, and hence is at least a three person interaction rather than a simple one to one situation.

Training of volunteers is essential to their success. They need preparation for dealing with the retarded, clarification of their own roles, and orientation to the institution, its staff and its policies.

Control of volunteers' activities by local parent associations can avoid many problems with institutions.

Recognition of volunteers' contributions by their own organisation is important.

Volunteer services must be adequately administered, supported and financed. Encouraging recent developments include the use of full-time professional coordinators of volunteers in some institutions, England's "Link Scheme", the new Youth-NARC program in the United States, and the federally-founded Foster Grandparent Program in the United States.

MODELS FOR RESIDENTIAL SERVICES

At least two viable models currently embody most principles adopted by the Symposium: the decentralized institution, consisting of small living units scattered within the community, and the simplified community-like institution which maintains active interaction with the rest of the community. Characteristics of both models can be found in various combinations.

Regardless of the specific model of residential services, residents should, whenever feasible, live in one place and work, attend classes, engage in recreation and participate in other social activities at other places to approximate the normal rhythm of life.

The Principle of Normalization is applicable to a wide variety of residential settings, and it should serve as the basic guideline for the design of facilities and programs. Normalization techniques which have proven very successful with most retarded children and adults may be modified to the degree that such modifications are more successful in developing normalized behaviour in individual retardates. Therefore specially designed equipment and environment, as well as specialized procedures, which deviate from the culturally normative patterns may be appropriate for seriously handicapped children and adults.

The concept of a sheltered "village" is often an attractive prospect to parents, since it may maximize their children's comfort and happiness. Since the primary goal of programs for the retarded — as is the case with normal children — should be maximizing human attributes rather than simply maximizing happiness, residential centers should never isolate their residents from the rest of the community.

A major caution regarding the village concept is the danger that when people are collected together in isolation there is greater risk of the loss of human rights.

The special community of the institution should not be separated from the normal community by an impenetrable curtain; it must not be a closed community.

The institution which is structured as a simplified community can offer greater freedom for certain types of residents than could be found elsewhere. For those who cannot move freely in the environment of the broader community, the simplified facility can offer a broader living area.

The special community can have greater concentration of staff with special expertise to meet the special needs of the retarded than would be available in the general community.

Research is needed to evaluate the relative merits of different models of residential services, using the degree to which they maximize their residents' human qualities as the basic criterion of success.

SYMPOSIUM CONCLUSIONS

(1) Residential services should be viewed as one segment **of a** continuum of services available to the mentally retarded. These services should be administered and interrelated to insure easy transition **from** service to service, based on the unique needs of each retarded at any given time. The concept of lifelong ,,institutionaltzation" is inappropriate for the great majority of retarded persons.

(2) Program planning for the individual retardate should be **based** on analysis of his unique needs at any given time rather than on **a** static diagnosis. Since these needs change with time, it follows **that** periodic re-evaluations are essential.

(3) The basic goal in programming for the retarded is to maxi mize their human qualities. The effectiveness of programs, including physical environments, should be evaluated on the basis of the degree to which they achieve this goal.

(4) Congruence between the physical environment of the residential unit and residences in the community being served **will** tend to optimize the human qualities of the retarded residents. **There** may be instances, however, in which specialized environmental modi fications will increase the retardate's ability to control his environment and to choose among alternative courses of action. To the extent that such modifications enhance the retardate's human qualities, they **are** in harmony with the principle of normalization, even though they **might**

result in physical environments that differ markedly from the cultural norm.

(5) Small living units and grouping of retardates into small groups are considered essential to maximizing their human potentials.

(6) The hospital model is inappropriate for residential services for most of the retarded. Special training is in no way uniquely qualifying for administration of mental retardation services. The multidisciplinary team is the preferred approach to programming for the retarded.

(7) Parents should play an important role in residential services for the retarded. They should be involved in general policy making as well as in close cooperation with staff regarding details of programming on the living unit.

(8) Retarded residents should not be used as part of the residential facility's work-force, unless they are hired as regular members of the staff. This principle does not negate the value of assignment to work stations as part of specific vocational training programs. Likewise, performance of chores related to daily living, such as keeping one's bedroom cleaned or making one's bed, is a valid aspect of the normalization process.

(9) Although the specific size of a residential center will differ with the characteristics of the cultural matrix within which the center is located, it must be recognized that increasing size tends to foster self-containment and separation from the remainder of the community. Large specialized facilities are likely to generate self-fulfilling prophesis.

(10) Children should live in separate living units from adults. The needs of the two groups differ so that they require different physical environments and programs. Transfer from children to adult units facilitates modification in self-concept of the maturing retarded resident.

(11) Research is needed to evaluate the relative merits of different models for long-term residential services, using maximizing of the resident's human potentials as the basic criterion. At least two viable models currently embody most principles advocated by the Symposium: the decentralized institution physically scattered within a community, and the simplified community-like institution which maintains active interaction with the community.

(12) The relationship between parent and child residing within **a** residential center should remain as congruent with the normal cul tural pattern as possible.

(13) Volunteers performing services in residential facilities should not replace staff or be used to alleviate manpower shortages. Volunteers can serve the extremely valuable function of catalyzing rapprochement between residential centers and the remainder of the community.

(14) Parents can work most effectively with residential centers by uniting into organizations. Such associations can consider issues with greater objectivity than individual parents.

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