MENTALLY RETARDED ADULTS IN THE COMMUNITY:  
SOCIAL POLICY AND THE NORMALIZATION OF  
SERVICES FOR DEINSTITUTIONALIZED ADULTS

by

GODWIN ONUOHAPERI

B.Sc.(Hons) The University of Ibadan, Nigeria, 1969

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF  
MASTER OF SCIENCE  
in  
THE FACULTY OF GRADUATE STUDIES  
DEPARTMENT OF HEALTH CARE AND EPIDEMIOLOGY

We accept this thesis as conforming  
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA  
August 1981

© Godwin Onuoha Eni, 1981
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.
ABSTRACT

The purpose of this study was to explore the nature and content of the social policy of "normalization" in community based services which have been used to meet the needs of de-institutionalized mentally retarded adults. In the process it was hoped that data would be obtained to aid decision makers in planning community services for retarded adults.

The study was directed to examine the relationship between the levels of normalization in services which had been provided for retarded adults who were discharged from the Provincial institution for mental retardation - Woodlands - under the medical administration of retardation services as well as after the assumption of same responsibility by the Ministry of Human Resources. These administrations represented the medical and the social systems of service delivery. "Normalization" had been adopted as "policy" soon after the transfer of responsibilities by the Ministries.

Three areas of concern were examined: Levels of normalization of services; needs of subjects; and normalization as policy. These areas had been central to public discussion of retardation issues in British Columbia.

In order to examine the three areas, normalization was defined in the Greater Vancouver Area of study using the explicit judgement of citizens and the implicit judgement of professionals. From their judgements, a criteria for measuring normalization was developed and used in scoring
individual services according to the special features of those services. A total of seven service areas were scored: Residential, Social, Medical, Recreational, Educational, Psychological and Vocational. The needs of subjects were identified from institutional records and scored. Five service characteristics were further examined for normalization. These were the nature, type, name, location and degree of integration. An integrated framework for policy analysis as well as empirical results were then used to analyse findings.

The study showed that community services were essentially deviant in orientation; that level of normalization were about the same for each five year period of study; that services were inadequate in meeting needs; that there was lack of coordination in delivery of services; and that "normalization" was a principle rather than a policy of the Provincial Government.

Implications for policy development as well as areas for further research have been suggested.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>1.1</td>
<td>General Background to the Issue</td>
</tr>
<tr>
<td>1.1.1</td>
<td>Historical and Philosophical Approaches</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Historical Theories of Mental Retardation</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Modern Approaches</td>
</tr>
<tr>
<td>1.1.4</td>
<td>Social Factors and New Ideologies</td>
</tr>
<tr>
<td>1.2</td>
<td>Normalization Ideology</td>
</tr>
<tr>
<td>1.3</td>
<td>The Issue in British Columbia</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Policy Development: Medical</td>
</tr>
<tr>
<td>1.3.2</td>
<td>Policy Development: Social</td>
</tr>
<tr>
<td>1.3.3</td>
<td>Human Resources Takeover</td>
</tr>
<tr>
<td>1.4</td>
<td>Voluntary Effort</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Public and Voluntary Effort</td>
</tr>
<tr>
<td>1.5</td>
<td>Services for Retarded Adults</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Services Under L.I.F.E. Program</td>
</tr>
<tr>
<td>1.6</td>
<td>The Issue</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Statement of the Problem</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Purpose of the Study</td>
</tr>
<tr>
<td>1.6.3</td>
<td>Operational Definitions</td>
</tr>
<tr>
<td>1.6.4</td>
<td>Research Questions</td>
</tr>
<tr>
<td>1.6.5</td>
<td>Hypotheses</td>
</tr>
<tr>
<td>1.7</td>
<td>Brief Plan of Study</td>
</tr>
<tr>
<td>1.8</td>
<td>Organization of the Thesis</td>
</tr>
<tr>
<td>2.0</td>
<td>REVIEW OF LITERATURE</td>
</tr>
<tr>
<td>2.1</td>
<td>Concept and Meaning</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Implications of Meaning</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Classification</td>
</tr>
<tr>
<td>2.2</td>
<td>Labeling and Deviance in Mental Retardation</td>
</tr>
<tr>
<td>2.2.1</td>
<td>Societal Reaction</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Models of Care</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Models of Society</td>
</tr>
<tr>
<td>2.3</td>
<td>Social Policy</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Domain of Social Policy</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Formulation of Mental Retardation Policy</td>
</tr>
<tr>
<td>2.4</td>
<td>Institutionalization; De-Institutionalization and Community Living</td>
</tr>
<tr>
<td>2.5</td>
<td>The Normalization Principle Revisited</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Interpretations of Normality</td>
</tr>
<tr>
<td>2.5.2</td>
<td>Rights of Normality</td>
</tr>
<tr>
<td>2.5.3</td>
<td>Normalization Studies and Arguments</td>
</tr>
<tr>
<td>2.5.6</td>
<td>Dimensions and Implications of Normalization</td>
</tr>
<tr>
<td>2.6</td>
<td>Community Adjustment of De-Institutionalized Mentally Retarded Adults</td>
</tr>
<tr>
<td>2.7</td>
<td>The Retarded Adult in the Community</td>
</tr>
<tr>
<td>2.7.1</td>
<td>The Nature of Community Services</td>
</tr>
<tr>
<td>2.8</td>
<td>The Needs of the Retarded Adult</td>
</tr>
<tr>
<td>2.9</td>
<td>Summary</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>PAGE</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>3.0 CONCEPTUAL AND METHODOLOGICAL GUIDELINES</td>
<td>104</td>
</tr>
<tr>
<td>3.1 Policy Concept</td>
<td>104</td>
</tr>
<tr>
<td>3.1.1 Policy Analysis</td>
<td>106</td>
</tr>
<tr>
<td>3.2 Normalization Concept</td>
<td>108</td>
</tr>
<tr>
<td>3.3 Needs and Services</td>
<td>110</td>
</tr>
<tr>
<td>3.4 Design of Study</td>
<td>110</td>
</tr>
<tr>
<td>3.4.1 Determining Normalization in Greater Vancouver Region</td>
<td>111</td>
</tr>
<tr>
<td>3.4.2 Organization and Design</td>
<td>115</td>
</tr>
<tr>
<td>3.5 Summary</td>
<td>117</td>
</tr>
<tr>
<td>4.0 PROCEDURE AND METHODOLOGY</td>
<td>119</td>
</tr>
<tr>
<td>4.1 Limits of Study</td>
<td>119</td>
</tr>
<tr>
<td>4.1.1 Population</td>
<td>119</td>
</tr>
<tr>
<td>4.1.2 Area for Study</td>
<td>120</td>
</tr>
<tr>
<td>4.1.3 Periods Under Study</td>
<td>120</td>
</tr>
<tr>
<td>4.1.4 Assumptions and Limitations</td>
<td>121</td>
</tr>
<tr>
<td>4.2 Procedure</td>
<td>123</td>
</tr>
<tr>
<td>4.2.1 Stage I</td>
<td>125</td>
</tr>
<tr>
<td>4.2.2 Stage II</td>
<td>129</td>
</tr>
<tr>
<td>4.2.3 Stage III</td>
<td>131</td>
</tr>
<tr>
<td>4.3 Method of Study</td>
<td>133</td>
</tr>
<tr>
<td>5.0 RESULTS AND ANALYSIS</td>
<td>135</td>
</tr>
<tr>
<td>5.1 Empirical Results</td>
<td>135</td>
</tr>
<tr>
<td>5.1.1 Needs and Services</td>
<td>139</td>
</tr>
<tr>
<td>5.1.2 Distribution of Subjects in the Community</td>
<td>142</td>
</tr>
<tr>
<td>5.1.3 Distribution of Community-based Services</td>
<td>146</td>
</tr>
<tr>
<td>5.1.4 Intellectual Level and Social Age</td>
<td>152</td>
</tr>
<tr>
<td>5.1.5 Normalization Content in Services</td>
<td>159</td>
</tr>
<tr>
<td>5.2 Summary of Empirical Results</td>
<td>187</td>
</tr>
<tr>
<td>5.3 Policy Analysis</td>
<td>191</td>
</tr>
<tr>
<td>6.0 SUMMARY, CONCLUSIONS AND IMPLICATIONS</td>
<td>200</td>
</tr>
<tr>
<td>6.1 Summary</td>
<td>200</td>
</tr>
<tr>
<td>6.2 Conclusions</td>
<td>202</td>
</tr>
<tr>
<td>6.3 Implications</td>
<td>203</td>
</tr>
<tr>
<td>6.3.1 Implications for Policy Making</td>
<td>203</td>
</tr>
<tr>
<td>6.3.2 Implications for Further Research</td>
<td>204</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>206</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>221</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.</td>
<td>Implicit and Explicit judgement of Normalization of Services and Percentage agreement by Professionals</td>
</tr>
<tr>
<td>2.</td>
<td>Distribution of Items as percentage of subgroup populations.</td>
</tr>
<tr>
<td>3.</td>
<td>No. of services received and not received as percentages of identified needs/services for each subgroup.</td>
</tr>
<tr>
<td>4.</td>
<td>Distribution of Subjects to Residential Facilities as percentage of subgroup populations: Male and Female.</td>
</tr>
<tr>
<td>5.</td>
<td>No. of percentage distribution of services not received, but identified at time of discharge: Males Groups A and B.</td>
</tr>
<tr>
<td>6.</td>
<td>No. and percentage distribution of services received but not identified at time of discharge: Males Group A and B.</td>
</tr>
<tr>
<td>7.</td>
<td>No. and percentage distribution of services not received, but identified at time of discharge: Female Groups A and B.</td>
</tr>
<tr>
<td>8.</td>
<td>No. and percentage distribution of services received but not identified at time of discharge: Female Groups A and B.</td>
</tr>
<tr>
<td>9.</td>
<td>No. and percentage distribution of recorded intellectual level for male and female subjects: Groups A and B.</td>
</tr>
<tr>
<td>10.</td>
<td>No. and percentage distribution of recorded intellectual level: Male Groups A and B.</td>
</tr>
<tr>
<td>11.</td>
<td>No. and percentage distribution of recorded intellectual level: Female Groups A and B.</td>
</tr>
<tr>
<td>12.</td>
<td>No. and percentage distribution of recorded social age level: Male and female subjects: Groups A and B.</td>
</tr>
<tr>
<td>13.</td>
<td>No. and percentage distribution of recorded social age level: Male Groups A and B.</td>
</tr>
<tr>
<td>14.</td>
<td>No. and percentage distribution of recorded social age: Female Groups A and B.</td>
</tr>
</tbody>
</table>
Table  | Description                                                                 | Page  
--- | --- | ---  
15. | No. and percentage score for each measure of normalization content: Male and Female Groups A and B. | 161  
16. | Total no. and percentage score for each measure of normalization content: Male Groups A and B. | 163  
17. | Total no. and percentage score for each measure of normalization content: Female Groups A and B. | 163  
18. | No. and percentage score for each measure of normalization content: Male Group A and Female Group A. | 165  
19. | No. and percentage score for each measure of normalization content: Male Group B and Female Group B. | 165  
20. | No. and percentage of services scored per level of normalization: Male Groups A and B. | 167  
21. | No. and percentage of services scored per level of normalization: Female Groups A and B. | 169  
22. | No. and percentage distribution of service characteristic score per level of normalization: Male Groups A and B (Residential, Social, Medical, and Psychological Services). | 170  
23. | No. and percentage distribution of service characteristic score per level of normalization: Male Groups A and B (Recreational, Vocational, Educational Services). | 172  
24. | No. and percentage distribution of service characteristic score per level of normalization: Female Groups A and B (Residential, Social, Medical and Psychological Services). | 179  
25. | No. and percentage distribution of service characteristic score per level of normalization: Female Groups A and B (Recreational, Vocational, and Educational Services). | 183  

LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Schematic diagram of study procedure</td>
<td>124</td>
</tr>
</tbody>
</table>

APPENDICES

<table>
<thead>
<tr>
<th>Appendix A</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Certificate of approval for research</td>
<td>221</td>
</tr>
<tr>
<td>(ii) Permission request letters - Institution</td>
<td>222</td>
</tr>
<tr>
<td>(iii) Permission request letters - Community</td>
<td>223</td>
</tr>
<tr>
<td>(iv) Permission request letters - Volunteer Sector</td>
<td>224</td>
</tr>
<tr>
<td>(v) Permission letter: Ministry of Human Resources</td>
<td>225</td>
</tr>
<tr>
<td>(vi) Sample permission letter - Volunteer Sector</td>
<td>226</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appendix B</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Letter to panel of judges</td>
<td>227</td>
</tr>
<tr>
<td>(ii) Definitions</td>
<td>228</td>
</tr>
<tr>
<td>(iii) Closed questionnaire</td>
<td>229</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appendix C</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Measures of Services and Criteria</td>
<td>230</td>
</tr>
<tr>
<td>(ii) Measures of Individual Services</td>
<td>231</td>
</tr>
<tr>
<td>(viii) Measures of Individual Services</td>
<td>232</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

The writer expresses his appreciation to the Ministry of Human Resources and to Local Associations for the Mentally Retarded for permission to obtain the necessary data for this study; to Drs. Anne Crichton and Patricia Woodward for acting as consultants during the difficult planning stages and to my wife, Mrs. Jacinta Eni for support during the long hours of data gathering and analysis.

Appreciation is also extended to the National Institute on Mental Retardation (NIMR) for providing a Fellowship Award which enabled the completion of the study. Finally, I wish to express sincere appreciation to Dr. Morton Warner, Dr. Vance Mitchell and Professor Anne Tilley for providing guidance as members of the study committee.
CHAPTER 1.0
INTRODUCTION

This thesis has been developed to explore the nature and content of the policy of "normalization" toward services which have been provided for previously institutionalized, mentally retarded adults from Woodlands - a provincial institution at New Westminster, British Columbia. The study is retrospective, and aims to: (a) examine the relationship between needs and services, (b) analyse the process of social policy and (c) provide data to aid decision-makers in planning community-based services for retarded adults.

One area of concern which has gained considerable attention and controversy is: "what is to be done with people who are not 'normal' by society's standards?" This concern has been less of a problem for handicapped children as for handicapped adults. Society has generally tended to be more sympathetic to the needs of children, and this sympathy has been used to develop policies and services which are targeted more to those needs. As a result, the presence of mentally retarded children in the community raises less controversy than does the presence of similar adults. In part, the controversy is due to the historical treatment which has been accorded persons who are mentally retarded. At various times they have been sources of superstition, misunderstanding, fear, sorrow and amusement (Barr 1904). Consequently, they have been worshipped, imprisoned, or left to die as outcasts of society (Kanner, 1964).
More often, they have been given labels which stigmatize and differentiate them from the rest of society (Ryan and Thomas, 1980).

However, the evolution of public concern for the retarded has been centered around the assertion of difference between people and the concept of deviancy. The assertion of difference is seldom neutral and implies some kind of social distance. On the other hand, the concept of deviancy encourages distinction which makes it difficult for those persons so labelled to appear as ordinary people (Rowitz, 1981). Therefore, public concern for mental retardation has been handled in different ways which often repeat over time. These measures include: destroying the deviant person; making the deviant person undeviant usually through education, treatment, and training; preventing deviancy by the means of birth control, early detection of genetic abnormality, good health care and preventive medicine; and by redefining social policy and philosophy.

In general, society has not been able to sort out its feelings about mentally retarded citizens. Reformers, at all times tend to argue that mentally handicapped\textsuperscript{1} people are not

\textsuperscript{1}The term "handicapped" is considered less stigmatizing than "retarded". The Vancouver/Richmond Association for the mentally retarded is presently considering a resolution for name change to "the mentally handicapped." Both terms are used interchangably in this thesis.
so different from other people. Therefore, they should not be treated differently but should be given, at least, some of the rights and opportunities others have (Wolfensberger, 1972). However, those who emphasize the differences argue for a more segregated life for the mentally retarded. They see the goal of reducing the differences between the handicapped and the rest of the society as either impossible, because their potential is limited, or simply as undesirable (Throne, 1975). However, the real argument seems to be over the feasibility of minimizing these differences through education, training or integration into society; and whether it is worth devoting considerable resources to doing so.

Another area of concern to reformers is public attitude towards the mentally incompetent. Gottwald (1970) has shown that the public generally associate the phrase "mentally retarded" with birth injury, defects, brain damage or generally severe forms of mental retardation. Begab (1968) had previously found that people tend to view retarded persons as sick or physically handicapped. That in the absence of a specific referent, most people conceptualize severe forms of retardation as well as deviancy. This has led to calls for a reduction of medical influence in the area of mental retardation as well as strategy for influencing public attitude towards more favourable experience. (Ryan and Thomas, 1980, Neufeld, 1980).

At present, issues about the way to provide services for mentally retarded persons do not often surface to confront the
public conscience. However, these issues may be the subject of considerable debate among special interest groups, agencies, the government, and practitioners who are directly associated with those in need of services. Occasionally, the layman hears about what is needed and what is not available because a news-worthy event, usually with criminal overtones, involves a mentally retarded person. From time to time, a crusading journalist will decry the apparent lack of adequate services, or a particular group will publicize the need for alternatives to those already in existence; or offer solutions or suggestions for what should be provided.

These intermittent outbursts bring action in the specific areas to which they are directed, but the whole issue of what to do with society's mentally retarded members remain far down the list of priorities for public conscience and purse. The layman accepts the whole question of mental disability as a medical problem if it appears to require medical treatment; as a "welfare" problem if the inflicted person is not capable of supporting himself; and as a judicial problem if this person runs afoul of the law. However, it is society's perception of mentally retarded persons as sick persons which has led to the development of services based on medical treatment with doctors and nurses as caretakers and a diagnostic framework for treatment. On the other hand, judicial problems have been complicated by the notion of incompetence and a denial of right to due process. Nevertheless, the issue of determining the magnitude, the range and the quality of retardation
problems and services within the Community, and the extent of government's responsibility, has to be faced.

In recent years, public debate has centered on the provincial government's policy to de-institutionalize, "normalize," and integrate mentally retarded persons into their communities, as well as the perspective under which such a task is to be accomplished (Donnellan, 1980, Brown, 1980). The debate has occupied the attention and activities of the volunteer sector and the Ministry of Human Resources in British Columbia. For four consecutive years, the British Columbia Association for the Mentally Retarded (BCAMR) passed resolutions requesting the provincial government depopulate provincial institutions for mental retardation, stop plans for capital expenditures in institutions, prevent further admissions, develop community services for the integration of former institutional residents, and return them to their local communities.\(^2\)

Elsewhere in Canada the debate has expanded to involve caregivers in institutions. The Ontario Public Service Employees Union (OPSEU, 1980) has published a Report on de-institutionalization and community integration programs in Ontario. This report suggests that many mentally retarded

---

2. The 23rd Annual Conference of BCAMR at Nanaimo specifically resolved that the government develop plans to prevent further admissions to institutions by Dec. 31, 1980: Resolution: No. 21; and to return all institutional residents to the community by same date: Resolution No. 23.
persons have been discharged to highly unsatisfactory community situations where they receive mere custodial care. The report is critical of the policy under which institutional residents are placed in the community without adequate community services, and makes the observation that improvement in institutional programs may be preferable to inadequate community services.

It might be suggested that caregivers in British Columbia institutions are equally apprehensive of de-institutionalization and "normalization" policies. More recently, the debate has begun to assume wider media coverage in an effort to gain wide public understanding and sympathy. Sometimes, newspaper articles portraying the beneficial effects of institutional and community integration programs for retarded adults, have appeared simultaneously. (Goad, 1981).

In a public letter addressed to all provincial members of the Legislative Assembly, the British Columbia Association for the Mentally Retarded (BCAMR) raised the following issues with the provincial government: ³ (a) that the principle of normalization regarding the rights of retarded persons to live in their home communities has not been effected; (b) that

³ Other issues raised in the letter dated May 14, 1981 relate to funding arrangements and fund allocation for community based services, federal cost sharing arrangement and the need for strategic plans.
process of de-institutionalization has been slowed four years after government's "guaranteed" commitment; (c) that community living alternatives and community based resources have fallen below expanding need.

The Minister of Human Resources responded by reiterating the government's commitment to the "principles of normalization" and the expansion of community services for mentally retarded persons. The Minister further observed that "it would be a disservice to move residents before the supports were there" and opted for careful planning to ensure success.

The issues involved in this debate are elaborated later on in this chapter. However, it could be said that the volunteer sector is unhappy with the rate at which institutionalized persons are returned to the community. They would like to see the development of more community based services to meet individual needs. At the same time these advocates seek adherence to the principles of normalization to which the government is also committed.

A key question therefore relates to the relationship between de-institutionalization and "normalization." Are these concepts synonymous? If not, how does the development of services relate to either or both. What, therefore is the content and process of "normalization" in the services already in place? What is "normalization?"
de-institutionalization and normalization principle, the government has opted for another look at the policy. Or, has the government underestimated policy implications before the commitment to return mentally retarded persons from institutions to their communities?

Records indicate that in the past five years, 279 mentally retarded persons have been released into the community from Woodlands - the largest of the provincial institutions. Also there have been more than 400 releases from Woodlands since 1969. However, the population of Woodlands only declined by 7% in the last five year period. This has been explained as resulting from new admissions and referrals for detention and treatment from the courts (Goad, 1981).

The fact is that more than 900 persons have been de-institutionalized from the three provincial institutions and returned to the community since 1969. Some of them had been released before the introduction of the "principle of normalization" in services. This study therefore is about the process and content of normalization in community-based services which have been used to address their needs. It also seeks to determine whether their needs are adequately addressed by these services.

In order to have a better understanding of the problem,

4. These figures have been calculated from the Annual reports of the Ministry of Human Resources 1969 to 1980.
it is necessary to describe the general background to the issue, the concept of "normalization," and the specific background to the problem in British Columbia.

1.1 General Background to the Issue

Mental retardation services in Canada or in British Columbia have followed much the same process as in Great Britain or the United States of America. Canada inherited from Britain a number of concepts about insanity, mental retardation and criminal behaviour. These are delineated either as Federal or as Provincial responsibilities by the British North American Act of 1867. Jones (1960) traced the development of services in Britain, and notes the growing acceptance of the idea of diversified system of care. Deutsch (1949) charted the history of the care of the mentally ill and the mentally retarded in the United States along similar lines.

In Britain, as indeed in North American, the kind of attention given to people who exhibit mental disorder and deviance has been a function of the way in which their behaviour has been classified or how they have been perceived. Crichton (1980) suggests that the term mental disorder is diagnostic and treatment oriented, but in attempting to control the residual deviance of mental disorder, society has had great difficulty in sorting out and labelling it, and in distinguishing between the limits of tolerable and deviant behaviour, and between the criminal and the insane. Armour (1979) also observes that formal attempts to meet the needs
of the retarded in Canada, as in Great Britain, went hand in hand with efforts on behalf of the mentally ill. In all respects, the general attitude of the Canadian Society paralleled those of their contemporaries in Britain and the United States of America.

1.1.1 Historical and Philosophical Approaches

Approaches to the problem of mental retardation are rooted in the broad philosophical, religious, economic, political and socio-cultural changes that had taken place in Western Europe before the 19th Century. Seen as markedly different from most people, in appearance or behaviour, mentally retarded persons generally became part of a larger group of devalued persons recognised by society as different or deviant. The fact that mental retardation and mental illness were lumped together shows the lack of a critical focus. Therefore, retardation, like all other forms of deviance, was considered in either superstitious or supernatural terms (Maloney and Ward, 1979). This resulted in a pattern of inconsistency and vacillation in sentiments or behaviour towards persons perceived as mentally incompetent. Consequently, they were, at one time, perceived as "subhuman organisms," menace to society, objects of pity, or as burden of charity (Barr, 1904). At other times they have been considered as "holy innocents" or as developing persons (Kanner, 1964). Therefore, they have either been conferred with less than full humanity and rights or they have been deified. In other words, they have either been segregated, destroyed,
confined, persecuted or controlled; or pitied, sheltered, given happiness or paternalized.

During the middle ages, the nature of the mind was considered to be within the realm of philosophers, and the "care" and "cure" of mad men was delegated to the church and its bishops and priests. During this period, the church inspired benevolent approaches to the retarded (Barr, 1904). By the end of the middle ages, which was characterized by indifference, there were a variety of responses. The retarded were allowed to roam the streets of European cities unmolested. A select few served as court jesters and many were regarded as "prophets of God" (Kanner, 1964). However, by the 18th Century the treatment of the retarded has reached a low point, and both Calvin and Luther denounced them as "filled with Satan" (Menolascino, 1979).

Maloney and Ward (1979) characterize this period as pre-scientific. First, there was little awareness of either intelligence or of mental retardation. Second, what little awareness that existed was really a recognition of extreme deviance, and there was no real concern for them or provision for their care and treatment.

Late in the 18th Century, men like Jean-Marc Itard and Johann Guggenbuhl recognised a need for the scientific study of the causes of deviance. They introduced the concept of careful training and their approach was educational. However, with time, there were severe criticisms because there were no
"cures" for mental retardation. Others like Sequin, who opted for individualized instruction, did not fare too well (Maloney and Ward, 1979). This led to the filling up of institutions because expected discharges of residents into the community rarely occurred. Furthermore, early enthusiasm resulted in increased referrals for help. The institutions were therefore forced to dilute the services they could provide, further weakening the potential for improvement in their clients. This led to expansion and a corresponding decrease in quality of care (Ryan and Thomas, 1980).

In analysing these early periods, it is important to note that only severely retarded persons were involved. It is known at the present time that these persons have serious neurological problems which preclude full remediation regardless of the quality of education they receive. Since it has been recognized that mental retardation was "incurable," the notion of custody began to supplant that of education. The return of residents to the community was no longer in consideration. Schools became "asylums," and "asylums" became institutions and permanent custodial shelters (Helsel, 1971). Residents training began to focus on service-type tasks to enable institutions become less expensive and self sufficient, thus, ushering in an era of vocational and occupational training.

1.1.2 Historical Theories of Mental Retardation

The fortunes of the mentally incompetent also depended on whatever current theory has been advanced either politically
or scientifically in the society.

The Theory of Heredity, generally referred to as the Degeneration Theory led to the belief that "heredity taint" could be expressed in different forms of diseases such as mental illness or mental retardation. The assumption was that the experiences of parents affected their offspring. The theory was ultimately an environmental one which led to the belief that "negative traits" could be prevented with less indulgence (Saranson & Doris, 1969). Alcoholism and sexual excesses were some of these "negative traits." Hence, there were calls for social reforms which indirectly affected the mentally retarded.

Charles Darwin's theory of the "Origin of Species" advanced the concept of variation, natural selection and the transmission of variation through inheritance. Darwin explained life in terms of struggle for existence and the survival of the fittest. This led, for the first time, to focus on individual differences and later to the discovery of mild mental retardation and the development of intelligence test (Begab, 1974). Persons whose behaviour went previously un-noted or were attributed to various forms of character defect, were thrust into the limelight. Begab (1974) reports that the application of intelligence tests to army troops in the first world war, revealed an alarming number of young men performing at mentally, subnormal levels. Within a short while, mental retardation became recognized as a social problem.

However, the public image of retarded persons as damaged
persons could not survive these new revelations. Attention was focused on socially troublesome families during the early part of the 20th century. This gave rise to the Eugenic movement which based its philosophy on the sociological theory of "Social Darwinism," which says that society was subject to the same principles of natural selection as plants and animals, and only the fittest would survive. The movement concluded: that there were more retarded persons in the society than was realized; that the retarded accounted for virtually all of the current social ills; that heredity was the major cause of retardation; and that society would soon be destroyed unless drastic measures were taken (Menolascino, 1977). These measures include putting the retarded to death, restrictive marriage laws, control through life segregation, and sterilization. Thus began the movement for the institutionalization of the "feebleminded" which has remained part of modern approaches to the issue of mental retardation.

1.1.3 Modern Approaches

As we have seen in the historical overview, the approach to mental retardation changed over the centuries. The philosophical underpinning of current social policy were established by the time of the Renaissance.

The Renaissance man used "humanism" to emphasize preoccupation with things human, in contrast to the theological orientation of his medieval predecessor. Humanism stressed the "dignity of man" and sought to maximize his growth and
development. This coincided with the emergence of individualism. Together, both contributed to the fall of "feudal" bondage. Allegiance to monarchs was gradually replaced by the idea of social contract between the individual and the state. This culminated at the Age of Revolution in America and France. The essence of these revolutions was the declaration of individual human rights as embodied in the American Bill of Rights and the French Declaration of Rights.

Consequently, the first half of the 19th century witnessed dramatic appeals for changes in the treatment of all the oppressed, afflicted, and handicapped. This led to the rise of advocate groups on behalf of prisoners, poor people, slaves, the insane and the mentally retarded (Ryan and Thomas, 1980). Thus, the fate and interests of the retarded have become linked, as before, with those of changing social attitude and philosophy.

Today, among those to whom the retarded and their problems are most visible and of the greatest concern, attitudes toward those identified as mentally incompetent are characterized by a relaxation of anxiety and a swing towards a more optimistic point of view concerning potential for education, training, and meaningful social participation within the community.

However, the idea of the institution as a treatment and containment centre for congregate care has persisted in spite of new ideologies. As has been discussed earlier, the original asylum was not conceived or intended as a life-long institution,
rather, as places where "idiots" could be trained for a period of years for as long as they made progress. However, there was nowhere for them to return. Families were scattered and untracable or unable to accept an "idiot" member however well trained. Public institutions of all kinds - for the old, the sick, the insane, the criminal, and the young - were built in increasing numbers and sizes.

Ryan and Thomas (1981) attribute the rise of asylums and institutions to problems of idiocy and heavy strains on family life. Rothman (1971) suggests that the change from local to institutional solutions was part of a panic reaction to the rapidly changing world of the late 18th and early 19th centuries. Scull (1979) also suggests that in England, the rise of specialist asylums signified a shift in the way in which the poor, the dependent and the deviant were contained. Public workhouses, as opposed to domestic relief, were increasingly used for all those who could not or would not support themselves economically. Thus, asylums of all kinds were seen as positive reforming forces or instruments of social change.

Over time, medical men became managers despite the fact that educationists had taken the initiative in setting them up. At the same time, society was becoming increasingly altruistic, and more concerned about the welfare of the underprivileged, the poor and the sick. In the last two decades, new pressure groups have become more militant and challenging than the long established charities. Small self-help groups
of parents and advocates have appeared and highly critical, not just of lack of adequate care in institutions, but also, of the attitude of professionals (Ryan and Thomas, 1981). They are not only concerned with "how human" but also with "how normal" the care and services of their children have been. Together with volunteer groups, their early concern for children has been expanded to include adults.

Consequently, and partly because of pressure, governments have begun to explore ways of improving services that are made available to even the most severely retarded adults (Eni, 1980). The emphasis appears to be in the direction of integrating the mentally retarded back into the society. In many ways, ideological principles have been used as the basis of social policy and this has grave implications for the mentally retarded, both on personal and on social levels.

1.1.4 Social Factors and New Ideologies

Industrialization, urbanization and universal education are social trends and forces which have had implications for the mentally retarded.

Nelson and Crocker (1978) state that "the advent of an urban, industrialized society, with its emphasis on skilled labour and timed productivity, constrained the social and economic self-sufficiency of the mentally retarded person." Technological advances and the complexity of life and work have made the requirements of existence and survival more
difficult. Labour became more specialized, and the capricious laws of supply and demand provided little security and stability. Overall, industrialization demanded a more intelligent work force, and this had profound effect on the less intelligent.

As man became increasingly urbanized along with industrialization, further changes occurred in life styles. City life became more complex especially within smaller confines. It required knowledge of how to set the clock, judgement about the right time, ability to read complicated bus schedules, filling of job applications and interviews. In other words, the requirements of urbanized, industrial environment demanded more difficult set of skills and abilities. Therefore the adaptive potentials of the less intelligent people are tested more frequently and more stringently in modern environment.

With industrialization, there was need for education which, in turn, required intelligence. This further made the requirements for existence more complex and difficult. With the establishment of mass education, the plight of the slow learner first became recognized, hence the development of intelligent tests and the concept of special education movement. For the social contracts of democracy to work, man has to be educated. Education was no longer a privilege or luxury of the rich and well born, it has become a necessity and birthright of all citizens.

In recent years there has been major changes in the philosophy regarding the care of the handicapped or the
retarded. The notion of asylum or institution has increasingly been abandoned with a concomitant increase on community care in various alternative settings (Bruininks et al, 1980). These alternative settings are expected to breakdown the social and economic walls that isolate the retarded from meaningful experience and learning. Some of these settings or ideologies have been described as medical, independent, consumer oriented, integrative or normalizing.

The medical ideology was the first to evolve and has dominated over the years. The focus is on eliminating or reducing an individual's disability and is tied to the utilitarian, dependency-productive model (Safilios - Rothschild, 1970). The goal is improved performance, behaviour or work, and encompasses diagnosis and treatment (Tepperman & Timeny, 1979).

Within the last few decades, emphasis has been placed on the restoration of as much independence as possible to enable the disabled take the responsibility for care and to become more active (Anderson, 1978). This ideology does not place the disabled into a category where they are expected to adapt to society or to return to normal or to work.

More recently, in the United States and Canada, disabled consumers have started to subscribe to their own interpretations in which services and independent living are mutually
exclusive.\textsuperscript{5}

The integrative ideology implies that disabled persons be integrated into the social and economic mainstream of society alongside the able bodied. It seeks to discontinue the segregation of the handicapped into separate groups (Falta, 1976).

However, the ideology which has attracted considerable attention everywhere including British Columbia is the "normalization ideology." This ideology is the basis of public policy in British Columbia in the last five years and a source of public debate with respect to services for the mentally retarded.

1.2 Normalization Ideology

Over the past ten years, there has been a strong and persistent movement to provide more normal experiences for mentally retarded persons. This movement has been largely based on the principle\textsuperscript{6} of "normalization" (Nirje, 1969). It means;

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.

\footnotesize
\textsuperscript{5} An organization of mentally retarded adults in British Columbia known as "People First" organization subscribe to this model as well as to other ideologies which give them responsibility for their affairs.

\textsuperscript{6} The terms "principle" and "ideology" are used interchangeably in this thesis.
Services for the retarded in Scandinavia where normalization principle has been more firmly embodied in their ideology have been used as model for the development of services in North America. Smaller "integrated" facilities are being developed in conjunction with plans for de-institutionalization. School systems have adopted "integration" or "mainstreaming" policies and efforts are being made to provide non-sheltered employment for handicapped people (Gottleib, 1975). These relatively new developments are being undertaken to enable the mentally retarded lead as normal a life as possible. Towards this end, the needs of mentally handicapped people are seen as basically similar to those of ordinary people with the difference that they may not be able to meet these needs unaided or as independently as other people can; and that they may have additional needs (Jay, 1979). The argument is that mentally handicapped persons do not have to live separately from others in order to meet their needs; or that special services they need should be provided in places where they live, such as the institution, but could be met through the general medical and social services as are other people's special requirements.

7. The term "integration" is used in Great Britain while "mainstreaming" is more commonly used in the United States.

8. The word handicapped is used here to include the mentally ill for whom the principle of normalization is also advocated.
The term "normalization" can mean different things to different people. Some people see it as a commitment to a normal lifestyle "within the community" and the right to be treated as an individual (Jay, 1979). From these interpretations come the recommendations for a flexible system of small group living, and an end to the domination of nursing care. Others propound the idea of a hospital as a normalizing environment "which whilst not normal in itself will nevertheless help to normalize people" (Gunzburg, 1973). But many of the advocates of normalization maintain that "a person is a person first, the handicap is secondary" (Nirje, 1976), and that the retarded "are ordinary people who must have rights and duties similar to those of every other citizen" (Bank-Mikkelson, 1976).

The assertion that mentally handicapped people should have equal rights with all other citizens often has a hollow ring to it. The United Nations declaration of the rights of mentally handicapped people which includes their right to special services and adequate care and treatment, simply poses the question: who is going to implement these rights and how? For example, a right to equal pay for women will be of little concrete benefit if there are no available jobs, or inadequate provision for child-care services to ensure ability to use any improved opportunities they are presented with. The implication for the mentally retarded will be to ensure that they are actually able to use services and that there is adequate human and social support for them to do so. There is also the right to make informed choice of occupation, of friends,
of leisure activities or of life-style.

The implementation of such rights would make great demands on the attitudes and responses of an increased number of people who would, either, voluntarily or accidentally, come in contact with mentally retarded people. It would also undoubtedly require more money being spent on the mentally retarded. The question of financial cost has been one which many reforming groups have either dodged or tried to prove that their proposal would not cost any more than present institutional arrangement.9 Others have argued that within the terms of welfare economics, increased investment in the training of the mentally handicapped would bring long-term economic benefits from the wages they would eventually earn and their contribution to the total economy (Conley, 1973).

The term "normalization" has also been accompanied by phrases such as "equality of opportunity," or "human dignity and respect" (Wolfensberger, 1972; Neufeld, 1980). These associated phrases generally tend to raise questions of ethics or morality, but in specific terms, the boundaries are not quite clear. This is especially true when there is an attempt to determine "what is normal." Different societies have

---

9. This is the position of the British Columbia Assoc. for the Mentally Retarded (BCAMR) and the Community Living Society, (CLS). See Annual Conference Reports, BCAMR 1976 - 1980. Also, see footnote 24.
different shades or normality. What is "normal" in a given society or culture may be deviant in another. This issue is examined in more detail in Chapter 2.0.

In more specific terms, Wolfensberger (1972) and Gunzburg (1973) relate normalization to particular environments. It is regarded as "culture specific," depending on the prevailing abnormal circumstances that need to be normalized. Therefore it is important to determine what is and what is not normal in a given society, or community.

Wolfensberg and Glenn (1975) outlined four dimensions of normalization ideology for practical purposes. These are discussed in greater detail in Chapter 2.0. In essence they are (a) non-deviant social interpretations, (b) non-deviant structures, (c) social and physical integration, and (d) provision of human rights. The first three dimensions are central to this study. The fourth dimension - human right - has not been measured, but has been analysed under a general framework for policy analysis together with the implications of normalization.

1.3 The Issue in British Columbia

In British Columbia, as indeed in North America, the kind of attention given to people who exhibit mental disorder and deviance has been a function of the way in which their behaviour has been categorized. Warham (1973) observes that categorization may be essential to what equality can mean in
practice and the pursuit of it as a social goal. It makes and remakes distinctions between categories of people and categories of need in relation to each other. Attempts to meet the needs of the mentally retarded went hand in hand with efforts on behalf of the insane. Those who did not stay with their families were sent to the "asylum," originally a place of safety for the less well to do. Families with sufficient means sent their retarded members to private nursing homes (Armour, 1979). In all respects the general attitude of the Canadian and British Columbian Society paralleled those of their contemporaries in Britain and the United States with respect to the mentally ill and the mentally retarded.

1.3.1 Policy Development: Medical

As has been noted earlier, the problem of coping with mental abnormality is demonstrated by changes over time. These changes have oscillated from conditions of support to those of control.

Bates (1977) and Armour (1979) recall that initially, there was no concerted policy for the mentally retarded as a group in Canada or in British Columbia. Such persons were first hidden by their families (Armour, 1979) and then housed in institutions which had been located away from the mainstream of society (Bates, 1977).

Prior to 1974, mentally retarded persons in British
Columbia, as in the rest of Canada, were made the responsibility of the Ministry of Health under the Mental Health Act.\textsuperscript{10} The prevailing policy considerations did not differentiate the mentally ill from the mentally retarded. Under the umbrella of the Ministry of Health, the focus of services was treatment oriented as well as custodial. Both the ill and the retarded were housed collectively at the provincial psychiatric hospital at Essondale, now known as Riverview. Consequently, the mentally ill were admitted through the provincial mental health hospital.

However, the passage of the School Mental Defectives Act in 1953\textsuperscript{11} enabled all mentally retarded persons to be admitted directly to Woodlands.\textsuperscript{12} Bates (1977) observed that there was rapid growth in the population of Woodlands leading to long waiting lists for children and adults and the development of two other provincial institutions.

There are two important observations to be made during

\begin{itemize}
\item \textsuperscript{10} Mental Health Act. Statute of British Columbia 1964.
\item \textsuperscript{11} School for Mental Defectives Act. Statute of British Columbia 1953.
\item \textsuperscript{12} Woodlands, the largest and oldest of the three provincial institutions was opened in 1919 "to educate, train and socialize those under our care, and to have them healthy, happy and contented..." (Bates, 1977). Woodlands has been the focus for reform in British Columbia by the volunteer and advocate groups. Others institutions are Glendale near Victoria and Tranquille in Kamloops.
\end{itemize}
this period. The first is the involvement of health agencies and the medical profession, almost exclusively, in the diagnosis treatment and institutionalization of mentally retarded person. The second is the intent to shift from medical involvement to educational involvement.

The involvement of the medical profession has been described as the "medicalization" of mental retardation (Ryan and Thomas, 1980, Rowitz, 1981). The term "medicalization" refers to defining behaviour as a medical problem or illness and mandating that the medical profession provide some kind of treatment (Conrad, 1975). This concept implies that sociologically or psychologically based problems can be defined as medical problems. Fox (1977) connects the increase in medicalization to such factors as the so-called medical mystique of physicians, the biotechnological capacities of modern medicine, and the influence of the medical profession. Ryan and Thomas (1980) argue that medicine - it's institutions, personnel, concepts and modes of explaining behaviour - has been the main instrument for excluding mentally handicapped persons from society; that the medical model of thinking tends to support the status quo by focussing on the subnormality of the individual rather than the subnormality of the environment.

The passage of the School for Mental Defectives Act in 1953 appears as an attempt to separate the retarded from the ill toward the "educationalization" of the mentally retarded. This attempt seems to be an indication from the provincial
government that retardation may not mean illness. But in 1964, mentally retarded persons were brought under the Mental Health Act (note 10), although they have always been kept in "asylums" with the mentally ill. This seems to be a reversal of the intent of the School for Mental Defectives Act of 1953.

The policy by which mental retardation services was administered under the Mental Health Act or made the responsibility of the Ministry of Health, may be described as clinico-medical as well as custodial. Although the influence of educationists was being felt at the time in British Columbia, nevertheless the bulk of orientation for care was essentially medical. In a review of developments in mental retardation in Canada from 1964 to 1970, Mooney (1971) observed apparent inconsistency in British Columbia. He observed that provincial institutions appeared to be moving from the "medico-custodial concepts and programs to educational concepts and training." He also noted that a special division with responsibility for mental retardation but parallel to mental health services division had also been created with the introduction of the Mental Health Act. Later, Bates (1977) will argue that institutional transition from medical to education and training concepts did not quite take place to any meaningful level.

1.3.2 Policy Development: Social

Consistent with the trend toward normalization and integration ideologies in the early 70's, governments in Europe, United States of America and Canada began to consider new
policies with which to provide mental retardation services.

Initial effort had been directed generally towards the welfare of children. In Great Britain, the effort which began in 1948 with the Children's Act, culminated in the recommendations of the Warnock Committee in 1978 and its acceptance by the government in 1980. The Children's Act had given local authorities duty to return children to their own homes wherever possible. The Warnock Committee proposed the extension of the concept of special education need and the abolition of statutory categories of handicapped children.\textsuperscript{13} Shearer (1980) analysed the efforts to address the issue of handicapped children in Great Britain and came to the conclusion that they represent policy failure. It was not until the Report of the Jay Committee (1979) that the needs of handicapped adults began to be seriously considered.

Efforts in Great Britain parallel those in the United States. The Education for All Handicapped Children's Act of 1975 enables the "mainstreaming" of all children in classrooms in the United States of America.

In Canada, a major study titled "One Million Children"

\textsuperscript{13} The Report of the Committee of Enquiry into the Education of Handicapped Children and Young People: (Special Education Needs) also examined and recommended the "concept of Integration;" and Government accepted the recommendations in a special white paper titled: Special Needs in Education which was presented to parliament in August 1980.
exhaustively looked at problems and services for handicapped children.  

Clarkson (1973) looked at Mental Health and Retardation Services in Manitoba and recommended that mental retardation programs should be: (a) separate from mental health programs, (b) regionalized, (c) decentralized from their institutional base, and (d) developed in local communities. He also recommended a new Mental Retardation Act, separate from Mental Health Act which should define the legal status of the retarded. The Report went further to suggest the involvement of the volunteer sector in the development and expansion of facilities.

The Clarkson Report was made at a time when the ideology of normalization has begun to emphasize the importance of the total environment, and how institutional environments contribute to the burden of being handicapped (Wolfensberger, 1972). The needs of retarded persons are increasingly being seen as similar to those of ordinary people. There may be additional needs which require assistance or specific services. Some

needs may involve normal access to social, emotional and sexual relationships; normal growing up experiences; the possibility of decently paid work; or choice and participation in decisions affecting their future. In general, it would appear that the thrust of the normalization movement is consideration for social and individual needs of mentally handicapped persons.

1.3.3 Human Resources Takeover

In 1974, the responsibility for mental retardation in British Columbia was transferred from the Ministry of Health to the Department of Human Resources. Consequently, mental retardation institutions and facilities were released from the prescriptions of the Mental Health Act. In effect, the transfer of responsibility from Health to Human Resources represents a shift in public policy from one of Clinico-Medical-Custodial model to integrative - Social Systems model.

One reason for the change in policy as stated in the Department's Annual Report (1975) is:

a growing public awareness that retardation is not an illness, and that training in Social skills is the single most important emphasis in service delivery.

15. The Dept. of Human Resources became the Ministry of Human Resources in 1975.

16. This was achieved through an Order in Council B.C. Reg. 416/74.

17. Other reasons relate to federal cost sharing arrangement for social services as well as a need to organize separate services.
The objectives of the Department are stated as follows:

- to provide the opportunity for every mentally retarded person to achieve his or her maximum potential.
- The retarded adult will have a right to economic security and opportunity to engage in meaningful occupation as determined by his or her capability.
- Departmental services including those for retarded persons are to be seen as being available to all citizens of the province based on need rather than on a label or category.

In 1976, the Ministry of Human Resources applied the word "normalization" in referring to the interests of mentally retarded persons in British Columbia, and has continued to regard normalization of services as its objective. Furthermore, in 1980, the Ministry published an Inventory of Services to Handicapped Children and Adults and indicated commitment to:

(a) provide full range of Ministry services to both the retarded adult and the handicapped child and their families,
(b) enable the greatest number of retarded adults to live in their communities in the least restrictive environment that will most fully meet their needs and enhance their independent functioning.

The document also stated that:

-- no retarded person should be admitted to Woodlands whose needs can be met in his own community, and no one should remain in the institution once his needs can be met elsewhere.

These policy statements indicate: (a) commitment to

18. The reference first appeared in the Annual Report of 1976 and has continued to appear since then.
de-institutionalize Woodlands facility, (b) the returning of previously institutionalized persons to their home communities, (c) the development of community based services, and (d) the provision of services according to individual needs.

The thrust of policy objectives appear to move strongly in the direction of a social system of services and away from the clinico-custodial system. Therefore, the expectation would be that community based services under the new social systems model will be significantly different from the medical model of delivery and much improved qualitatively. Such is the basis of assumptions in this study.

However, the release of the institutions for the retarded from the prescriptions of the Mental Health Act was not coupled with a new set of legislative guidelines. The institutions, more or less, operated in a "legal vacuum" until 1976 when the Guaranteed Available Income for Need Act - G.A.I.N. - was passed. The Act consolidated in One Act, the income assistance and social services legislation. This translated into specifying what kinds of services the province is willing to support financially in order to help the needy.

The policy provisions which concern income assistance under

19. The GAIN Act and its accompanying Regulations - B.C. Reg. 479/76 provide minimum income to the handicapped, citizens over 60 yrs of age, and social services such as residential care and rehabilitation services.
GAIN legislation relate to the general eligibility of retarded individuals for assistance under the rubric of handicapped persons. First, a mentally retarded person should be certified as a handicapped individual by a physician although he or she may not be required to undergo medical treatment. Second, an eligible individual must have exhausted all avenues of treatment and/or rehabilitation as well as actively sought employment. In practice this provision may be relaxed somehow for mentally retarded persons. Third, institutional persons are not eligible to receive income assistance but may receive comforts allowance and some are provided with cash for personal clothing purposes. On the other hand, income assistance is provided to eligible retarded persons who live independently in the community, or who live in privately funded facilities where the cost of care, plus a comforts allowance is less than the income assistance granted as handicapped persons' benefits.

The Community Resources Board Act of 1974 and the Human Resources Development Act of 1969 are two statutes which relate to institutional persons insofar as they affect the possibility of these persons moving back to the community. The first Act was repealed by the introduction of the GAIN Act. The second Act authorizes payment of a grant to a municipality, an incorporated society or a Regional Board.

---

20. The current value of Comforts allowance is fifty dollars monthly.
This provision enables the development of services and resources in the Community for Children and Adults.

A closer look at the GAIN Act reveals two important policy objectives. The first is a desire to develop community resources for Children and Adults. It should be noted that the need for services for children is not as pressing as those for adults since efforts in that direction have been addressed for quite sometime. The second objective is the maintenance of continuous link with the medical system of service delivery through eligibility requirements. In other words, medical entry into GAIN benefits would appear to prevent clean separation of the social systems model from the clinico-custodial model. The issue therefore is whether in fact, a difference exists in the manner services have been provided under the two policies.

1.4 Voluntary Effort

Bates (1977) notes that the initial voluntary effort in British Columbia was directed towards the "advancement of mentally retarded children." This effort was organized by persons who were interested in the welfare of handicapped children. In 1955, the Association for Retarded Children came into being and quickly expanded to 63 British Columbia Chapters by 1976.

Quite early in its history, the Association began presenting briefs to the provincial government. In 1959,
the Public Schools Act was amended to permit School Boards to take over the complete operation of classes for moderately retarded children.

Until 1968, issues regarding retarded adults were not pressing priorities, as the focus of the Association was children. However, in 1968, the Association changed its name to British Columbia Association for the Mentally Retarded (BCAMR) following a similar change of name by the parent body, the Canadian Association for the Mentally Retarded. The same year, the Provincial Association passed a Resolution petitioning the provincial government to:

provide capital and operating grants for residential homes for retarded adults and contribute to supporting training services for them.

The examination of the Association's Annual Conference Reports from 1967 to 1980 reveals the following trend:

(a) Initial priority was concern for children. There were voluntary activities at the provincial institution - Woodlands - to provide comfort for handicapped children as well as assistance with the management of waiting lists; (b) developments at the national and international scene led to advocacy role

21. The Resolution was passed at the 11th Annual Conference in Trail, B.C. This was the first indication of concern for retarded adults in the Annual Conferences since its formation.
and concern for improvement of living conditions within Woodlands, and later, within other provincial institutions;
(c) there was concerted effort in petitioning and later pressing the provincial government to develop community resources. Later, the Association undertook the direct operation of community services for children such as residential services. This has since been expanded to include adults. In recent years, local Chapters of the Association have undertaken a variety of direct services for children and adults with financial support from the provincial government; (d) the thrust of the "normalization movement" in the early 70's, led to a more militant philosophical standpoint and greater concern for the rights of retarded adults.

With normalization ideology as philosophical base, BCAMR broadened its goals as follows:22 (a) To achieve de-institutionalization for all institutional residents; (b) To return them to the community; (c) To advocate for the development of community services for mentally retarded persons; (d) To influence government policy towards the mentally retarded; and (c) To educate the public.

In general terms, the aims and objectives of the provincial government and BCAMR are similar with respect to philosophical base and direction of services. Both accept

the principle of normalization in policy development and both are committed to de-institutionalization, community integration of mentally retarded persons and the utilization of community based services. However, the government and BCAMR differ on the speed with which these common goals are effected. There is need, therefore to examine the process and content of what has so far been achieved by way of placing retarded adults in the community under the previous and present policy directions.

It should also be noted that presently in British Columbia, the volunteer sector or non-profit societies can operate and manage group homes or community residential services under contract with administrative Regions of the Ministry of Human Resources.\textsuperscript{23} Funding for Group Homes is provided by the government calculated on per diem basis, and negotiated annually from an approved budget. The volunteer sector as well as private individuals provide residential and other services at the local level. BCAMR does not participate in direct operation of these services but its local chapters do.

The participation of local chapters of BCAMR in direct service delivery has certain implications. First, the impact

\textsuperscript{23} Under the Community Care Facilities Licencing Act of 1976, non-profit societies may operate Group Homes. The Act also permits private individuals to operate proprietary or for profit Commercial Boarding Homes which must be licenced when there are 3 or more beds.
of BCAMR as an advocate group is limited in the area of direct delivery of services. The tendency is to focus on generalities rather than specific individual problems of their clients. This study looks at some of these individual problems. Second, the volunteer sector shares in any blame or deficiency which may be leveled on direct services if community placement of retarded persons prove to be a failure in communities. Third, dependence on government's financial support rather than voluntary sources limits ability to expand programs or to strictly effect the tenets and requirements of the normalization ideology.

1.4.1 Public and Voluntary Effort

The formation of an Association known as Woodlands Parents' Group, and a Society called the Community Living Society - CLS - add a new dimension which involves cooperation of the public and the volunteer sector in addressing the issue of services for mentally retarded persons.

Woodlands Parents Group - WPG - is made up by some parents of residents at the Woodlands institution. Its basic aim is to improve and possibly monitor living conditions at Woodlands. Several of its members later were instrumental in the formation of the CLS. However, both are separate organizations with overlapping membership. Also, their collective aim is to develop comprehensive community based system of
service.  

In a letter to the Minister of Human Resources, dated Feb. 24, 1977, the Woodlands Parents' Group called attention to the fact that developmental progress cannot be realized in the institutional setting, and stated their intention:

...to see to the development of community based services

...it is our feeling that the present climate in B.C. is ripe for the development of such alternative to the institution.

The same year, the Minister responded on behalf of the provincial government by launching what he called "a major effort to deinstitutionalize services for the mentally handicapped." This effort was code-named "Project LIFE" or Living Independently for Equality (Vander Zalm, 1977). The effort would "enable residents to move away from large institutions and initiate a variety of Community Services....that will assist such persons to live as independently as possible." In 1978, the Minister established the CLS:

24. The aims and objectives of the two organizations are detailed in two unpublished materials: (a) Development of a Comprehensive Community Based System of Service - Special Presentation to the Minister of Human Resources, 1977, (b) A Proposal for an Experimental and Demonstration Comprehensive Service Project for British Columbia. Community Living Board, BCAMR 1977.

to assist with the orderly planning and community placement of developmentally disabled persons and to encourage community services to serve these persons.

CLS therefore is a supplementary placement organization whose functional arm is the Community Living Board, CLB. The CLB enters into contracts with service providers on behalf of retarded adults from Woodlands. At the end of 1980, 48 mentally retarded adults have been de-institutionalized and placed in the community through the CLB (Goad, 1981). This is a far cry from the 200 adults at Woodlands the Society estimated as ready for community living in 1977. As a result, there has been some concern expressed by CLS regarding the intention of the provincial government in further carrying on with de-institutionalization. Sometimes, these concerns have been expressed through the media.

The budget for CLB activities is totally funded by the provincial government. The CLB has argued that its expenses in the community will be about half the cost of institutional care per adult at Woodlands, and has recently claimed a better than 90% success rate (Goad, 1981).

There are four observations to be made regarding the CLS and WPG. The first is that there is cooperation with the public sector in providing community services. In this regard, the government provides all the funding that is required and can conceivably limit funding if it is not satisfied with either policy direction or efficiency of operation. The second observation is the claim by CLS that
it is cheaper for a retarded adult to live in the community than in the institution. One may therefore want to know how the cost of community living has affected the philosophy of normalization. Although this is not an issue in this study, nevertheless, it may have important implications for future direction. The third observation is an assertion that institutionalized adults are not being returned to the community at a faster rate (Goad, 1981). One may again speculate whether this is a deliberate effort on the part of the government or a result of inadequate community resource. This study also looks at the type and adequacy of community resources that have been applied to individual needs. The fourth observation relate to membership of the CLS and the WPG. The majority of the membership of both organizations also hold membership to local Associations for the Mentally Retarded and consequently to BCAMR. Therefore, the philosophical basis for policy in all these organizations is the same.

1.5 Services for Retarded Adults

There are two types of services for retarded adults in British Columbia.26 These are (a) Adult Support Services and (b) Adult Residential Care programs or Services.

---

Adult support services or programs relate to basic income support under the Handicapped Persons Income Assistance Plan, (H.P.I.A.), for persons receiving handicapped benefits. As has been noted earlier on, eligibility for the G.A.I.N. Act and consequently for H.P.I.A. is through medical examination. Applicants must be at least 18 years or under 65 years of age, and have a monthly income less than the guaranteed level, and assets not exceeding $2,500 for a single person or $5,000 for a person with dependents. As of April 1979, the maximum monthly benefit, for a single person is $387.19. Persons receiving handicapped benefits are also eligible for full medical coverage, basic dental services, eye glasses, pharmaceutical care, transportation allowance up to $20 per month, and an incentive allowance for employment of up to $50 for a single person of $100 for a person with dependents.

Community involvement programs enables the recipient of HPIA, who is unable to work but able to participate in the provision of community services, to receive up to $50 in order to encourage participation.

Achievement Centres operated by non-profit societies may receive subsidies to enable them to carry on with programs designed to help people improve their social and work skills which will enhance the quality of their lives and increase their independence.

Another support service is the Community Living Board CLB which has been referred to in subsection 1.4. The CLB is
designed to plan the community placement of present and former residents of Woodlands, to encourage the use of community services for these individuals and to stimulate the development of appropriate new resources.  

Residential services are provided by government, the voluntary sector and private individuals (Note 23). The government administers the three public provincial institutions of which Woodlands is one (Note 12). Non-profit societies and private individuals operate a range of community based residential services under provincial licencing and contract with the Ministry of Human Resources. Community residential services include: (a) Foster and family homes which are private homes for one or two persons; (b) Group homes which provide accommodation for 3 to 14 persons. However, the Ministry recommends 6 to 8 residents in a group home. Altogether, there are 35 group homes with a residential capacity of 343 for adults in British Columbia; (c) Short stay Hostels which may serve as respite care residences or may be operated year round or for a period of months; (d) Proprietary Boarding Homes which are commercial enterprises with 3 or more beds; and (d) Independent Living Homes, generally referred to as "Apartment Training Homes" which are used to prepare adults to live


28. Inventory of Services, note 26. Also note 27.
independently.

1.5.1 Services Under L.I.F.E. Program

Under the "Living Independently for Equality" program - LIFE - the Ministry may allocate funds to provide one-to-one support to enable mentally retarded adults improve level of independent functioning in the community especially in the areas of financial management, use of transportation services, use of leisure time, personal hygiene, interpersonal relationships and job search skills.

1.6 The Issue

The larger issue is whether mentally retarded adults who are now institutionalized should continue to be placed in communities where they are expected to benefit from community services without being stigmatized or deprived of rights. This, of course relates to the readiness of the community to accept them, the availability of community resources to meet their individual needs, and the conditions of policy by which they are integrated in the community.

The specific issue is how well has the process of normalization been applied to community services which have been used to address the needs of de-institutionalized retarded adults. How adequate are these community services in meeting the individual needs of these adults? Has there been an effective change in policy direction from the medico-custodial system to the social service system? What are the implications
of the policy of normalization?

In this chapter, it has been shown that:
(a) Society has had great difficulty in sorting out and in dealing with problems of residual deviance associated with mental retardation. Therefore, it has oscillated its reaction according to prevailing ideology or attitude. Consequently, there is constant search for new policy directions amidst changing norms and changing social development.  
(b) There has been at least two policy directions in British Columbia since 1969 regarding mental retardation. These are the medico-custodial system by which issues of mental retardation had been medicalized, and the social system which is current and adopts the concepts of normalization for services intended for retarded persons. The implication being that the social systems policy provides better quality of service than the clinical system, and that normalization of services is the process for achieving better quality of care. (c) There is ongoing debate and controversy regarding de-institutionalization and the integration of retarded persons into the community. Whilst both the voluntary sector and the provincial government subscribe to the concept of normalization, however, they differ as to the speed at which this process is currently being effected. The government seem to prefer a more gradual process whereas pressure groups would like to see immediate depopulation of all institutions (note 2), thus bringing into conflict the policy of normalization and the process of de-institutionalization.
Therefore, in order to avoid a situation of "Social Trap" (Platt, 1973) and to determine the effectiveness of policy directions, it is necessary to: (a) examine how the policy of normalization has been applied to services used to address the needs of de-institutionalized adults who are already living in the community; (b) determine the adequacy of these services in meeting the individual needs of these adults in view of the objective to normalize their lives.

Woodlands, the largest and oldest of the three provincial institutions in British Columbia has featured prominently in the debate for de-institutionalization. Between 1969 and 1979 the population of Woodlands declined by 31%. 17% of this between 1969 and 1973 before the introduction of the social system of service. 14% of the decline is between 1975 and 1979 after a change in policy has been effected.30 Also in 1974, following a change in Policy, the situation was such that institutionalized residents were asked to discharge themselves, if they wish, at the age of 19. Consequently, there has been, and continues to be, a number of self

29. Platt makes the point that government and planners, like fish in fishtraps, proceed inexorably into situations which become increasingly hazardous or lethal and so unable to free themselves.

30. Figures have been calculated from Statistical Reports of the Mental Health Branch and Annual Reports of the Ministry of Human Resources for the given years.
discharged adults who are now receiving services in the community. Therefore, in order to plan for future services, it is necessary to examine how previously institutionalized adults, of all categories, have been treated in the community under the current policy.

1.6.1 Statement of the Problem

The study looks at the following:

(a) The policy of normalization (independent variable) and community services (dependent variable).

(b) Community Services (independent variable) and the needs (dependent variable) of mentally retarded adults.

(c) The relationships between dependent and independent variables.

(d) The influence of the following intervening variables: age, sex, level of intelligence and level of social quotient.

1.6.2 Purpose of Study

(a) To explore the nature of the normalization of services for previously institutionalized adults from Woodlands provincial institution for the mentally retarded.

(b) To examine the relationship of community based services to the needs of the study population.
(c) To provide data to aid decision-makers in planning community-based services for retarded adults.

(d) To analyse and to discuss the development of social policy and the implications of the policy of normalization in the area of mental retardation.

1.6.3 Operational Definitions

(a) Policy: The principles and courses of action adopted and pursued by the government of British Columbia as well as by various units within British Columbia (Gil, 1970) and includes all policies directed toward making change in the structure of society (Boulding, 1976). Specifically, the policy of normalization, as described in Chapter 3 is examined in the light of government's directions.

(b) Community Service: This refers to services which are provided in an area where people live and work under normal conditions. In this study, any measure used or is expected to be used in addressing a need is a service. (Chapter 3).

(c) Need: This is defined as a necessity which has been

31. See Chapter 3.0, Conceptual and Methodological Guidelines for more detailed definitions.
identified for a mentally retarded adults (19 - 40 yrs. of age) by a team of care givers at Woodlands at the time of Community Placement Conference. There are seven categories of need: Residential, Social, Psychological, Educational/Training, Vocational, Recreational and Medical.

1.6.4 Research Questions

In order to address the problem and achieve the purposes of the study, several research questions are identified:

(a) Are there differences in the nature of services before and after the introduction of normalization policy?

(b) Do services adequately address the needs of de-institutionalized retarded adults?

(c) Are existing services consistent with the policy of normalization as defined by the provincial government?

(d) Are Residential Services used restrictive, and are they integrated into the community?

(e) Are deinstitutionalized adults socially and functionally integrated into their local communities?

(f) Are any problems experienced with normalization policy associated with problems in the Community or problems with policy issues?
1.6.5 Hypotheses

Stated in the null form:

(a) That there is no difference in services provided for previously institutionalized mentally retarded adults before and after the introduction of a policy of normalization.

(b) That past and present services do not adequately address the needs of retarded adults living in the community.

(c) That services are not consistent with normalization.

1.7 Brief Plan of Study

The Study uses restrospective information on previously institutionalized, mentally retarded adults, male and female, who were, at least 19 years, but not more than 40 years of age at the time of placement in the community from Woodlands' Institution at New Westminster British Columbia. The characteristics of the Study population as well as Study limits are detailed in Chapter 4.0.

The Study population is divided into two groups - the pre-normalization Group A, 1969 to 1973; and the normalization Group B, 1975 to 1979. Both groups represent retarded adults who have been placed in or have self-discharged themselves to alternative community living arrangements before or after the adoption of the concept of normalization by the provincial Ministry of Human Resources. The groups are similar in the
sense that they are within the same age grouping and have been admitted to Woodlands from the Greater Vancouver area of British Columbia (Chapter 4.0).

Individual needs - Social, Medical, Psychological, Educational, Recreational, Residential and Vocational - which have been determined at time of Community Placement, are traced to community services used to address them (Kessner, et al, 1973). These services are then scored using criteria which has been developed for measuring normalization in Greater Vancouver area of British Columbia (Chapter 3.0 Appendix A). The criteria is based on a method for measuring process and outcome in which implicit and explicit judgements are required (Brook and Appel, 1973).

Services are then categorized and scored in five areas: nature, type, name, location and integration (Wolfensberger and Glenn, 1975). Further categorization is achieved by determining which services have been (a) identified as needed and were actually received, (b) identified as needed but were not received and (c) have not been identified as needed but were received.

In essence, the study is based on the premise that the policy of normalization leads to a better quality of care or of service. In other words, high levels of normalization leads to high levels of quality of care. The study is therefore, a process study which assumes that a measure of process is indirectly a measure of quality. Therefore, there are no
outcome measures in methodology.

Results are examined in two stages. First, data are statistically analysed to indicate relationships as required by the hypothesis. Second, two frameworks for policy analysis are used to further examine and discuss available data before inferences are made (Gil, 1976, Kerr, 1976 (a), 1976 (b)). The general issue of labelling and deviance is discussed along with policy analysis.

1.8 Organization of the Thesis

The first chapter includes general, historical and current background to the issue, a statement of the problem, the purpose of the study, research questions and hypotheses, and brief plan of study. Chapter 2.0 consists of a review of related literature. In Chapter 3.0 Conceptual framework as well as design of study are discussed, and the criteria for measuring normalization is developed. Chapter 4.0 provides a description of the procedures used in conducting the study and the methodology applied. Chapter 5.0 presents the results and an analysis of data as well as integration of the frameworks for policy analysis. The Sixth and final Chapter summarizes the findings of the study and sets forth conclusions and implications for further study.
CHAPTER 2.0
REVIEW OF LITERATURE

The literature on community living and normalization of services for mentally retarded adults is broadly based, varied and often contradictory. This is partly due to different interpretations, concepts, methodologies and professional standpoint from which the problem is viewed. However, the bulk of available information on community living for retarded persons relate to de-institutionalization, community residential services, and attitude of residential care-givers but little information on individual needs. Also, available literature relate mostly to the American scene and quite limited on the Canadian environment.

In this chapter, literature pertaining to the issue raised in Chapter 1.0 is presented with respect to: concept and meaning; labelling and deviance; models of care; social policy; institutionalization, de-institutionalization and community care; normalization; needs; and services. The format used is one which enables some discussion and/or analysis to elucidate findings or arguments. At the end, the Chapter is summarized to pull together specific aspects of literature which are most relevant to the theoretical framework and study design discussed in Chapter 3.0.

2.1 Concept, and Meaning

The concept of mental retardation is vague, indefinite
and complex although there is general consensus about what it should cover. It seems that professionals respond to the question "what is mental retardation?" by discussing what is not (Stevens, 1964, Smith, 1971) and by describing causes (Stevens, 1964). Consequently, the many different concepts, definitions and classification systems often tend to focus on the constructs of the particular profession rather than on the retarded individual. Thus, the sociologists set out to study retardation as a social problem, the psychologists as a psychological problem and the physicians as a medical problem.

Maloney and Ward (1979) consider the problem of the concept of mental retardation as a practical one which relates to a "deviant group," and which raises a number of responses. These responses have served a variety of legal, economic, social, administrative and bureaucratic purposes. For example, there is a need to develop a concrete set of criteria on which to base critical decisions on issues such as competency to stand trial, culpability for criminal acts, institutionalization, eligibility requirements for admission to special classes, and the formulation of laws.

Maloney and Ward (1979) further argue that expediency led to two aspects to the concept of mental retardation. These aspects are the social and the psychological. The social aspect tends to stress the manifest problem of social incompetence as the ultimate criterion, whereas the psychological aspect regards incompetence as latent.
Wolfensberger (1972) takes the view that social incompetence or incompetence is "culturally relative," highly complex, value laden, and variable. He argues that different cultures make different demands and have different expectations and levels of tolerance. Therefore, as a practical problem, the extent of mental retardation will vary with cultural context. As a result, he argues, the consideration of mental retardation as a medical disease becomes more congruous since the individual must be matched with his or her environment. Hence, retardation could become a temporary rather than a permanent condition especially for the mildly retarded. The same individual can be defined as "mentally retarded" or "normal" depending on the social system of which he or she is a part.

It is generally agreed that mental retardation is related to intelligence or at least the lack of it to some varying degree. As Robinson and Robinson (1965) note, all of the controversy concerning the nature of intelligence has a direct impact on the field of mental retardation.

Grossman (1977) defines mental retardation as follows:

Mental retardation refers to significantly subaverage intellectual functioning existing concurrently with defects in adaptive behaviour and manifested during the developmental period.

The Grossman definition which is accepted by the World Health Organization, (WHO), the American Association on Mental Deficiency (AAMD) and the Canadian Association for the Mentally Retarded (CAMR) has three requirements.
The first requirement relating to the person's level of general intelligence is operationally defined and measured by performance on an individually administered, standardized test of intelligence. The intelligence quotient (I.Q.) index derived from these tests serves to quantify the general level of intellectual functioning and is used as the practical criterion. The work "significant" is included in the definition for the very specific fact that the I.Q. cutoff for mental retardation is two or more standard deviations below the mean or average I.Q. of 100. In practice, and depending on the type of intelligence test used, this means that the upper cutoff point for mental retardation is an I.Q. of 68 or 70. Therefore all persons with I.Q.'s below this cutoff point satisfy the requirement for a diagnosis of mental retardation, namely, significant subaverage intellectual functioning.

The second requirement relating to adaptive behaviour represents a major historic shift in the diagnostic process. In the past, I.Q. alone was considered the sole and sufficient criterion for mental retardation. This practice is no longer appropriate since there must now be a manifest impairment in adaptive behaviour as well. If a person has no difficulty adapting to his environment, it is meaningless to consider him mentally retarded just because of a test score. Adaptive behaviour is therefore defined as the degree to which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. Since these standards are related and culturally variable,
this criterion is difficult to specify, and consequently to measure reliably. Maloney and Ward (1979), argue that since this criteria vary with age level, that there is a general expectation for increasing independence, self mastery, and conformity to societal demands and conventions as the person progresses from one developmental level to the next.

The third requirement regarding manifestation during the developmental period helps to distinguish mental retardation from a variety of other disorders where low I.Q. and adaptive impairment are present. For example, a graduate student or university professor suffering from "brain damage" secondary to an automobile accident may score well below 70 on an I.Q. test and manifest all sorts of adaptive impairments. Likewise, people with acute emotional disturbances are often quite impaired behaviourally and unable to perform well on the I.Q. test.

The "developmental period" refers to the time during which the growth of intelligence is presumed to occur. Practically, this is considered to be from the time of birth until 16 or 18 years of age,¹ although the upper limit is arbitrary and debatable.

---

¹. In British Columbia, the limit is eighteen years. Inventory of Services, Ministry of Human Resources, 1980.
2.1.1 Implications of Meaning

There are three implications of this definition of mental retardation. First, the definition says nothing about cause. Although several hundred aetiological conditions are known to associate with mental retardation, the definition ignores them in favour of a purely functional description. Mental retardation is therefore considered to be a state of behavioural impairment or social incompetence that has many causes.

The second implication is that the definition describes the current functioning status of the individual and no prognostic statements are implied. This is in contrast to past attitudes and practice, wherein the notions of "permanence" and "incurableness" were associated with the diagnosis of mental retardation, (Menolascino, 1977). The current view gives much greater recognition to the notion of changeability. Prognosis is now more related to such factors as associated medical conditions, motivation, treatment, training opportunities, and the environment.

The third implication relates to the concept of mental retardation. The tripartite definition asserts that I.Q. alone is no longer sufficient for a determination of mental retardation. Mental retardation has come to be seen as a culturally relative, socially defined, social-psychological problem, thereby attesting to the awareness and recognition of the changing concept by society.
2.1.2 Classification

A survey of literature reveals that a wide variety of parameters have served for different classification schemes, both historically and in current approaches. There are essentially six general parameters for classification: (a) severity of symptoms, (b) etiology of symptoms, (c) description of syndromes, (d) adaptive behaviour, (e) educational expectations and (f) grouping on a manifested behaviour basis.

Measured intelligence has been the most common criterion used in relation to the symptom severity parameter. Classification on this basis, necessitates grouping of intelligence quotient (I.Q.) scores in some fashion and identifying these groups with a designated term or label (Chinn, Drew and Logan, 1975). For example, Wechsler (1958) used groupings and I.Q. scores as follows: Borderline, 70-79; Moron, 50-69; Imbecile, 30-49; Idiot, 25 or below. The AAMD and the CAMR classify as follows: Borderline intelligence, 68 - 83 or -1 standard deviation (S.D.) from the mean; mildly retarded, 52-67 or -2 S.D.; moderately retarded, 36-51 or -3 S.D.; severely retarded, 20-35 or -4 S.D.; and profoundly retarded, 19 or below or -5 S.D. The Ministry of Human Resources in British Columbia uses four categories as follows: Mild retardation,
52-67 on the Stanford-Binet instrument, or 55-69 on the Wechsler scale (1958); Moderate retardation, 36-51, Stanford-Binet; Severe retardation, 20-35, Stanford-Binet; and Profound retardation, less than 20.

The second general parameter for classification is aetiology of symptoms. This involves primarily, the biochemical aspects of mental retardation and is most often viewed in a medical context, and may be termed medical classification. There are ten categories which include infection, trauma, metabolic disorders, brain diseases, chromosomal abnormalities, psychiatric disorders, environmental influence and associated other conditions. Approximately 75 to 85 per cent of the total population of retarded persons fall within the category of environmental influences (Chinn, Drew and Logan, 1975).

Classification is also achieved by describing syndromes and grouping of the symptoms. This method is mostly used by workers in the medical field. Syndromes are usually identified by observation of a pattern of physical and/or behavioral characteristics although physical descriptions tend to predominate (Carter, 1965, Grossman, 1977).

Adaptive behaviour or related concepts have been used as

functional parameters of classification (Sloan and Birch, 1955, Grossman, 1977). Adaptive behaviour as a classification parameter attends specifically to human development. There are four levels 1, 2, 3 and 4 which represent mild, moderate, severe and profound mental retardation respectively. Each level describes adaptive and social behaviours at the pre-school age, school age and adult stages of life.

Educability expectation is viewed as a parameter of classification (Scheerenberger, 1964). The educational classification approach is based on a statement or prediction of expected achievement. There are three categories - educable, trainable, and custodial - but some professionals have included a fourth category of dull-normal which ranges first above the educable in terms of measured I.Q. (Chinn, Drew and Logan, 1975).

The sixth parameter of classification is based on behavioral manifestations. This approach is popular in the areas of psychology of learning and education. It is based on behavioral observation of task performance, and differs conceptually from the previously discussed classification schemes. The framework is not concerned with grouping but is based on what skills a given individual has or does not have or to what degree he can perform a task. The focus is on the individual and his skill level rather than the individual in terms of his category (Chinn, Drew and Logan, 1975).
2.2 Labeling and Deviance in Mental Retardation

Much of the literature or discussion of mental retardation labeling relates to the attachment of a deviant tag or status to an individual whose behaviour does not appear normal to the identifier of the problem (Wolfensberger, 1972, Rowitz, 1974, Rowitz, 1981).

Labeling has been described as a process which occurs within the larger perspective of a community social system (Erikson, 1962, Glazer, 1971, Schur, 1979); and deviant behaviour as 'behaviour that people so label' (Becker, 1963). As the label "deviance" is conferred upon the acts or attributes of an individual by the audiences viewing the acts, deviance becomes a sociological problem in origin. If the label "deviant" is successfully applied, these individuals become deviant because of the attachment of the label. The sociological assumption is that the individuals will usually also accept the label, "deviant" (Becker, 1963, Schur, 1971, Rowitz, 1981).

The "labeling perspective" as briefly described above has recently come under increasing controversy because of its validity and limits (Schur, 1971, Hawkins and Tiedman, 1975, Gove, (ed), 1975, Suchar, 1978, Schur, 1979). This has important implications for mentally retarded persons. Labeling seems to refer to one thing only - the alleged unfavourable consequences produced by direct negative labeling of specific individuals. Critics, however, emphasize that the "deviantizing
process" (Schur, 1979) more broadly points to the fact that at every level of social life - in interpersonal interaction, in the processing of individuals by designated "social control" organizations, and in the generation of broad deviance conceptualizations and classifications at the societal level - deviance is always a social construction brought about through a characteristic process of social definition and reaction (Suchar, 1978, Ryan and Thomas, 1980, Schur, 1980). Therefore, the deployment of resources for social control helps to determine deviance outcomes (Erikson, 1966) and a given society is then likely to have the kinds of deviance it fears and perhaps even the amount of deviance it seeks out (Schur, 1980).

The above discussion partly explains why the perception and labeling of mentally retarded persons vary from one society or culture to another (Wolfensberger, 1972). The "interactionist concept" (Rubington and Weinberg, 1978; Goode, 1978) does not adequately explain the plight of retarded persons. Therefore, there is another dimension - that of social control mechanisms such as professionals and agencies.

MacMillan (1977) has argued that traditional sociological perspective on labeling is oversimplified. He then lists a number of factors which may influence the labeling of an individual as mentally retarded and affect the impact of the label on the individual. These are: (a) the individual's pre-labeling experience, (b) the effect of more
than one stigmatic label on the individual, (c) the effect of informal labeling by friends and neighbours, (d) the psychological impact on the individual, (e) the reaction of the family to the mental retardation label and (f) the actual label used in contrast to the several possible names for the same set of problems. Scheff (1966, 1975) argues that the medical model, specifically, procedures in the diagnosis of mental illness, is oriented towards the inner state of the individual. Therefore, the labeling approach does not conflict with an argument that medicalization of social problem is occurring (see Chapter 1.0 p. 27).

Rowitz (1981) reviewed Scheff's Labeling Theory of Mental illness in relation to mental retardation, and finds seven out of a nine-item labeling theory of deviance also applicable to mental retardation. However, he finds that the reality of labeling may never be understood by some retarded persons, but agrees with Mercer (1973) that despite public labeling in schools, many retarded children do not carry their mental retardation label into their home communities from school environment. Moreover, when the educational experience is over, the individual may lose the label completely (Hobbs, 1975, a, b.), although the denial of the label is more difficult for more severe forms of retardation.

Faber (1968) argues there is a distinction between deviance and competency. A deviant is an individual who voluntarily commits an act or engages in behaviour which
may lead to official labeling as a deviant. Other individuals may involuntarily commit acts or engage in behaviour which may lead to official labeling because of an inability to engage in socially acceptable behaviour. Faber further argues that mentally retarded individuals fall into this latter group. However, this distinction may be quite simplistic in that issues of competency may involve organic deficits on the one hand or social dysfunction by middle class standards on the other. Faber's argument may be true for the severely retarded but contentious for the mildly retarded.

Sheff (1966) also hypothesizes that labeling is the single most important cause of deviant careers. This may not be applicable to the general population of the mentally retarded. For the individuals who are labeled mildly mentally retarded, labeling may or may not affect them socially or psychologically (Mercer, 1973, Krasner, 1977). This reaction is often dependent on such factors as socio-economic status, race, and ethnic background. If mental retardation label does not carry over from school into community relationships, it becomes difficult to talk about a deviant career (Rowitz, 1974 b). In this study, the position is taken that the carry-over of deviant labels from Institution to the community leads to deviant type community services.

2.2.1 Societal Reaction

The point that societal reaction varies from society to society has been made earlier. However, it appears that a
shift has occurred from a consideration of the causes of mental retardation to a concern with how mentally retarded individuals are controlled (Rowitz, 1974 a) or their problems politicized (Schur, 1980, Ryan and Thomas, 1980). Agencies that treat special populations are found to be organized in such a way that the determination of appropriate cases for the agencies is often made quite independently of the acts, characteristics or qualities of persons coming to these agencies for service (Rowitz, 1974 a). Rowitz also found that the ideal type of agency case is often quite biased demographically and dependent on such variables is: the professional's conception of those who are sick and need help; the specific demographic characteristics of potential service users that any agency considers to be its clientele; and the pattern of interagency referrals that produces new clients. Also, the development and expansion of many alternative types of community services has been shown to affect the demography of service use and thus the labeling of individuals by various types of agencies (Rowitz, O'Conner and Boroskin, 1975).

Spitzer (1975) observes that the control of deviance is often achieved through containment - geographical, socio-psychological or moral. Goffman (1961) notes economic and interpersonal containment of the asylums for the mentally ill. In general each society seems to be asking questions such as: What functions do the deviants serve? What are the social and perhaps moral consequences for individuals being treated as "deviants?" What power base do they have? These concerns
therefore lead to the "politicization" of deviance and power struggle between those who are in a position to gain from the perpetuation of a role and those who want the role abolished (Schur, 1980, Ryan and Thomas, 1980). Various professional groups in the field of mental retardation have variously been perceived as influencing the degree of labeling and therefore deviance that occurs at any given time (Mercer, 1973, Ryan and Thomas, 1980, Schur, 1980).

2.2.2 Models of Care

Based primarily on Mercer's work (1965, 1973), two contrasting models on mental retardation have been delineated. These are the clinical and the social systems models.

Mercer (1973) notes that the clinical perspective classifies mental retardation as a handicapping condition which exists in the individual and can be diagnosed by clinically trained professionals using proper standardized assessment techniques. This model focuses on the individual in terms of "defect" and reflects the early root of mental retardation in medicine. The individual is considered to have an organic defect, and any change or cure is dependent on changing the faulty mechanism responsible for the inadequate or retarded behaviour. While this defect is typically considered to be of genetic - but not necessarily hereditary - origin, it could be non genetic, that is, the result of infection or deprivation. Mercer therefore concluded that the clinical model of care is the frame of reference commonly adopted by
persons in the helping professions, such as in the field of medicine, social work and education.

In quest for an answer to the question "who is normal?" Mercer (1973) observed two contrasting definitions within the clinical model. These are the "pathological model" contributed by medicine and the "statistical model" advanced by psychology and medicine.

The pathological model defines diseases by their biological symptoms. In this model, normal equals the absence of pathological symptoms and abnormal equals the presence of pathological symptoms. Biological manifestation is evaluated against a universal standard. Inductive logic becomes less crucial than in the statistical model, therefore findings which are generated within the pathological model frequently transcend societal boundaries. Thus; the disease model can be subsumed to be a universal model which is based on a bipolar construct - normal and abnormal, or cause and effect.

The statistical model defines abnormality according to the extent to which an individual varies from the average of the population on a particular trait. Intelligence quotients (I.Q.) are reported in standard deviation units which are the major criteria for determining levels of mental retardation. Further classification among the abnormal is achieved according to how many standard deviations an individual is below the mean. The greater the deviation, the more severe the abnormality.
Mercer (1973) concludes that the clinical definition of mental retardation is therefore based on a dual standard of normal - a pathological manifestation and a behavioral manifestation. That is, low I.Q. is equal to bad in a given society's social evaluation; bad is equal to pathology in the pathological model; therefore low I.Q. is equal to pathology. Hence, I.Q., which is not a biological manifestation but a behavioral score becomes conceptually transposed into a pathological sign which carries all the implications of the pathological model.

Mercer's inferences have been criticized by Gordon (1975) as failing to consider "the grossly organic complications which accompany such cases" and characterizes the statistical model as "oversimplification." However, Gordon notes that it has become quite common to discuss I.Q. norms in pathological terms.

Mercer (1973) describes the social systems model as classifying mental retardation as an acquired social status, and is derived from sociology rather than medicine. Sometimes called the "Social deviance model," it defines abnormality as behaviour that violates social systems norms (see section 2.2 and subsection 2.2.1). This has led to the consideration of mental retardation as a cultural phenomenon (Wolfensberger, 1972) or as a problem of the society (Dexter, 1958). Dentler and Erikson suggest that the mentally retarded may help maintain social group and class structures by helping
define the limits, standards, sanctions and group boundaries.
On the other hand, Faber (1968) considers the mentally re-
tarded as a surplus population which plays no part in the
organization of the society, and that society could function
without this surplus population. However, they contribute to
the maintenance of social structure through the creation of a
need for institutions for their treatment and care.

Mercer (1977) attempts to sort out the various parts of
the social systems model by identification of its character-
istics as follows: (a) it is a multidimensional model;
(b) there are norms for each role in each social system;
(c) it is an evaluative model - the values of the most power-
ful groups are enforced; (d) definition of behaviour are both
role bound and system bound; (e) it is necessary to specify
both the role and the system within which the assessment is
being made; (f) it is both a deficit model and an asset model
because the poor performers and the outstanding performers in
various social roles can be identified. Mercer (1973) con-
cludes that "mental retardate" is "an achieved social status
and mental retardation is the role associated with that status
------ it does not describe individual pathology, but rather
refers to the label applied to a person because he occupies
the position of mental retardate in some social system."

An implication of the social system model is that since
an individual participates in numerous social systems simul-
taneously, and moves in and out of social systems over time,
he may achieve the status of "mental retardate" at one time
and drop it at a later time.

2.2.3 Models of Society

Mercer (1977) describes two models of Society which
relate to the status of a group or culture in a given society.
These are the Conformity and the Pluralistic models of society.

The Conformity model visualizes "the social order as con­
sisting of one cultural tradition, that of the politically
and economically most powerful group." The institutions,
history, values, and life styles of the dominant group are
perpetuated as a matter of policy. The aim of education and
public policy is to acculturate the minority group to the
culture of the dominant group. The mentally retarded may
be regarded as a group to be acculturated into the dominant
culture of the non-retarded group. In the conformity model,
each culture or group is a small circle within a larger circle
which contains all small circles - a sort of melting pot.

Mercer (1977) argues that when the conformity model of
society is the basis for public policy, assessment practices
become part of the societal mechanism for enforcing and legiti­
imizing conformity. Consequently, testing based on conformity
model have been used to label, segregate and assign dispro­
portionately small numbers to classes for the gifted children
(Mercer, 1973).

The Pluralistic model is characterized by "cultural and
structural pluralism" and visualizes culturally diverse groups as organized around a core culture that consists of the basic economic and political institutions which hold the society together. There are varying relations between the various core groups or core culture. Some groups may be both culturally and structurally absorbed. Other groups may have been acculturated to the core group but have maintained sufficient structural separatism to remain identifiable. In this model, all cultures have equivalent value.

2.3 Social Policy

Kahn (1969) defines policy as a "standing plan," the product of rational exercise involving the determination of goals, the examination of alternatives, and the selection of a strategy. Tropman and Vasey (1976) suggest that in order to understand the meaning of policy, it is important to realize the extent to which political forces can shape and alter its character, and in time, can distort it. They defined the various dimensions of policy in the context of politics, planning, philosophy, or ideology and concluded that if policy is implemented by people who do not care, or who are opposed to the policy, the failure of follow-through can have the effect of "causing the war to be lost."

Boulding (1976) simply refers to social policy as "another name for government policy" and argues whether one wishes to distinguish social policy from economic policy. Titmuss (1974) makes the point that just as policy can be
taken to refer to the principles that govern action directed towards given ends, social policy can be taken to mean re-distributive command over material and non-material resources. In essence, it implies change - changing situations, systems, practices and behaviour. Crichton (1980) calls attention to the importance of boundaries in any context which involves policy making.

Black (1968) more specifically defines policy as "the general principles by which a government is guided in its management of public affairs, or the legislature in its measures." Stringham (1974) further refines the term policy by stating that policy is "...a major guideline for future discretionary action. It is generalized, philosophically based and implies an intention and pattern for taking action."

Mann (1975) proceeds to list several characteristics of policy problems: (a) they are public in nature, (b) they are very consequential, (c) they are complex, (d) they are dominated by uncertainty, and (e) they reflect and are affected by disagreement about the goals to be pursued. This suggests that at the very least, social policy (and hence normalization policy), is concerned with beliefs, attitudes and balance among relationships and resources. Quite often, the intent and purpose of a policy must be inferred.

2.3.1 Domain of Social Policy

Gil (1976) describes the domain of social policies as
dealing with the following elements of societal existence: (a) the overall quality of life in a society; (b) the circumstances of living of individuals and groups; and (c) the nature of intra-societal human relations among individuals, groups, and society as a whole. However, he cautions that "all past and extant social policies are considered to be casually related to the various social problems perceived by members of the society at any point in time." The conceptualization of the relationship between social policies and social problems does not negate the importance or the significance of specific policies as potential solutions to perceived problems.

In analysing natural and societal forces which limit, influence, and interact with the key processes and the general domain of social policies, Gil (1976) identifies three forces: (a) Limiting conditions: These are physical and biological properties of a society's natural setting and the biological and psychological properties of man, (b) intra and inter societal force fields: These include intra societal interest group conflicts; society's stage of development in cultural, economic and technological sphere; size and institutional differentiation and complexity of society; and personal, cultural, economic, and political interaction with extra societal forces, and (c) constraining variables: beliefs, values, ideologies, customs and traditions. In general, Gil's paradigm reveals a system of related moderations. For example: The overall quality of life and resource
development are dependent on: the Society's stage of development which is related to prevailing beliefs; on status allocation and the circumstances of living of individuals and groups which are constrained by values and ideologies; and on Rights distribution and intra societal human relations which are constrained by tradition. These factors affect the size and institutional differentiation; the complexity of society; and the cultural, economic and political interaction with extra societal forces.

2.3.2 Formulation of Mental Retardation Policy

Baumeister (1981) notes that the formulation of mental retardation policy is not an event, but a dynamic process that has identifiable components which operate over time: (a) There must be public awareness of a problem and a significant sentiment by powerful elements towards rectifying the problem; (b) laws and measures must be formulated for dealing with some important aspects of the problem; (c) programs must be designed, funded, and implemented; and (d) programs must be evaluated and modified.

Baumeister (1981) further comments that significant social policies evolve incrementally and partially over time, and are often altered by changing political social and economic contingencies. He suggests that sometimes, "ordinary knowledge" may be more important in the effort to deal with social problems such as mental retardation. By "ordinary knowledge" Baumeister (1981) refers to knowledge which is based on
common sense, intuition, experience, speculation, understanding of values, appreciation of political contingencies, or knowledge that does not owe its immediate origins to professional techniques.

2.4 Institutionalization, De-Institutionalization and Community Living

Larsen (1978) outlines two basic points of view regarding where mentally retarded and/or handicapped persons should be served. Some believe that institutions are the only, if not the best, alternative for retarded persons, (Throne, 1975); while others argue that services should be provided for all individuals, irrespective of their level of functioning, in the community. On the one hand it is argued that the state has usurped parental responsibilities for many years and that it is impossible or unfair to terminate such services now. That the handicapped are happiest and best adjusted when they associate with their own kind rather than competing with their more able peers where they experience failure. On the other hand it is argued that the handicapped benefit more from association with normal individuals of their own age group than they do from associating only with others who are similarly handicapped. That institutionalization denies the individual many opportunities to acquire normal behaviour patterns through the mechanisms of modelling and imitation. That the segregation of large numbers of mentally retarded individuals in large institutions facilitates and prolongs
It has been suggested that because the mentally retarded are so different from the general population, the public will never accept them into the mainstream of community life (Throne, 1975); or at least in their immediate neighbourhood without knowledge of their problems (Willms, 1978). It appears that those holding this line of argument are more concerned with the detrimental effect of social ostracism rather than they are with the beneficial effects of segregated living in institutional settings.

Are Institutions intrinsically bad? Perhaps, not. It has been suggested that institutions can, if given adequate financial support, become "healthy" places for even the most severely mentally retarded (Goldberg, 1975). This argument implies that institutionalization has been deleterious to the handicapped because insufficient resources have prevented the provision of adequate programs and care. Those opposed to institutions, argue that increasing financial support of institutions will not substantially improve their ability to serve their residents (see note 9, page 23). Larsen (1978) argues that institutionalization may be "least likely to harm an individual who possesses superior intellectual and behavioral abilities, and most likely to damage an individual who has intellectual or behavioral handicaps." In his view, community alternatives appear to have greater potential for providing better services and programs, at smaller or equal
costs than do institutions.

Goldberg (1975) reminds critics on all sides of the argument that it must be recognized that the majority of mentally handicapped persons do, however, live in the community. That there is no massive drive at the present time to incarcerate any individual who is mentally retarded and that the waiting lists in institutions are the lowest in history. He notes that there usually are special problems that the mentally retarded individual presents which leads to some form of supervised care; and warns that in damning the large institution, there is a danger of stereotyping the workers within the institutions as only interested in providing custodial care. Goldberg (1975) then concluded that "despite considerable handicaps, consistent and kindly care as well as a wide gamut of occupational and recreational activities do occur in institutions in Ontario."

However, Blatt and Kaplan (1966) in the United States of America, and Willingston (1971) in Ontario, Canada, have provided dramatic expose of dehumanizing conditions which exist in large residential institutions.

2.4.1 De-Institutionalization and Community Care

There are some who would define "de-institutionalization" as the discharge of residents or patients from institutions into the community. There are others who would include in their definition of "de-institutionalization," the provision
within a residential facility for a dignity of life consistent with the normalization principle (Goldberg, 1975). Higginbottom (1981) observes that successful de-institutionalization requires pre-existing, comprehensive, clinical, vocational and residential support services in a community based system. At the same time, Higginbottom suggests the integration of services, at least temporarily, with traditional health and mental retardation services including institutions.

It would appear that there is general agreement regarding one component of de-institutionalization, namely the discharge of institutional residents from institutions. However, it seems that there is disagreement with respect to where they go, why they go there, and how they are treated.

The thrust for the development of alternatives to institutional care for the retarded has come from the National Institute on Mental Retardation, (NIMR), sponsored by the Canadian Association for the Mentally Retarded (CAMR). The NIMR, CAMR and local chapters, have exerted a strong influence on provincial planners through publications, films, conferences, workshops, press releases, and advocacy. As a result, in almost all Canadian Provinces, deinstitutionalization projects have been planned and in some cases actually implemented. For example, Kinkaide (1977, 1980) has reported on the development of community services in the Regions of Edmonton, Alberta, which since 1972, have enabled 450 previously institutionalized mentally retarded persons to be placed in independent
or group home situations. Although some accounts have been
positive, others have reported questionable benefits (Murphy,
Rennie, and Luchins, 1972), or negative outcomes (Kinkaide,
1980). Murphy and his colleagues (1972) observed that even
in a "small" community facility: (a) there was very little
interaction between residents and family as well as a lack of
any activity whatever, (b) regimentation and uniformity were
common. For example; certain days were set aside for shaving
and others for bathing; and (c) in many cases, there was no
interaction between residents and other persons or facilities
within the community. Goldberg (1975) goes further to spec­-
ulate that in some of the natural homes of the mentally re­
tarded older individual, life could consist of sitting in
front of the television, without access to a peer group and
normal social interaction.

A number of critical reports of American de-institutional­
ization programmes have appeared in the past several years
(Reich and Siegel, 1973; Arnhoff, 1975; Bassuk and Gerson,
1978; Whitmer, 1980, Talbott, 1979, 1980) suggesting that,
in some states, large numbers of previously institutionalized
persons have been discharged from facilities with little or
no advance planning. As a result, these patients now live
lonely existence, while receiving inadequate services in a
hostile surrounding community. Most of these authors suggest
that de-institutionalization programmes have been politically
motivated with little regard for the needs of clients.

There appears to be an indication that large scale
reductions of institutional populations have occurred in the absence of adequately developed, alternative community resources (Bachrach, 1979). Furthermore, in many states, community based facilities have been administered in isolation from state operated institutions (Bassuk and Gerson, 1978) resulting in a lack of integration between the two systems. A number of authors have argued that reductions in institutional size must occur in tandem with the development of community based alternatives (Greenblatt and Glazier, 1975; Ashbaugh and Bradley, 1979). Other authors have stressed that importance of providing adequate rehabilitation services for clients in the community (Olshansky, 1980; Hatcher and Rasch, 1980).

Although most of the papers describing the American situation have dealt with psychiatric patients, parallel problems appear to exist with the mentally retarded. In discussing the de-institutionalization of mentally retarded persons, Scheerenberger (1976) criticizes the "experts" who have argued for the placement of the retarded in communities irrespective of the consequences for the persons involved.

On the positive side, Stein and Test (1980) have reported impressive results with the Mendota Project in Wisconsin. This is a carefully organized de-institutionalization programme providing strongly supportive, structured community services which are integrated with the state hospital system. However, Stein and Test have reported that for de-institutionalized persons to remain in the community, ongoing, active support services must be present.
In Canada, the most successful de-institutionalization programme appears to be the Saskatchewan plan. This programme is regarded as a model even in the American Literature (Neufeld, 1977, Bachrach, 1979). Like the Mendota Project, the Saskatchewan plan has provided for active structured ongoing community support, in a system which remains integrated with traditional mental health services.

Elsewhere in Canada, de-institutionalization programmes have not been systematic or planned without political expediency. As discussed previously, (Chapter 1.0 pages 5 and 6) the Ontario Public Service Employees Union (OPSEU)\(^4\) has raised issues with the Government of Ontario regarding de-institutionalization programmes. Lusthaus, Hanrahan and Lusthaus (1979) have reported that retarded persons "integrated" into community settings in Quebec have been functionally isolated from non-retarded people in the surrounding community. The authors also have reported anecdotally, however, that former institutional residents are generally pleased to be out of the institutional settings.

Scheerenberger (1974) has presented a model for de-institutionalization. He indicates that it should encompass three interrelated processes: (a) prevention of admission by

---

4. The OPSEU report (1980) alleges that discharges from Govt. institutions have been ordered on a quota basis without reference to the availability or quality of alternative community services.
finding and developing alternative methods of care and training; (b) return to the community of all institutionalized residents who have been prepared through programmes of habilitation and training which will enable them function adequately in appropriate local settings; and (c) establishment and maintenance of a responsive residential environment which protects human and civil rights and which contributes to the expeditious return of the individual to normal community living whenever possible.

2.5 The Normalization Principle Revisited

The Scandinavian countries have challenged the previous role models for the retarded and have created action-oriented legislation to facilitate change toward normalization.  

The laws or legislated statutes of the Scandinavian countries do not embody the entire framework of normalization intent; rather, they only represent the perceptible and more easily legislated corollaries of the principle. Appreciating the normalization ideology or principle is a difficult process, and thus it is very difficult to describe the many subtle implications.

When it is stated that normalization means treating the retarded person as normally as possible (Nirje, 1969) the logical question is "what constitutes normal treatment?"

---

5. See Chapter 1.0, Section 1.2.
Certainly, any model of normal treatment would involve individual and/or social values. To discern the implications of normalization principle then, one must view the concept as a change process. Just as the feminism movement is based on a change away from sex-role stereotyping, so the normalization principle is based on a change away from deviant role perceptions.

2.5.1 Interpretations of Normality

There are varying attempts at the definition of "what is normal" within the context of the normalization principle. To some people "normal" means "homelike," since institutional living is considered abnormal (Neufeld, 1980), or placement in a community setting such as a family care facility where the number of residents is fewer than ten (Maloney and Ward, 1979). Other people consider redesigning the environment in a "positive" way for better social functioning as essential to being normal (Gunzburg and Gunzburg, 1973; Neufeld, 1980). Wolfensberger (1972) regards normality as "culture specific" depending on what needs to be normalized in a given society. The author is aware that in many developing African countries, there are no institutions for the mentally retarded therefore no need to normalize the lives of institutional residents in these countries. It is normal for the "extended family system" to provide for the care of retarded persons in the society.

However, there are many types and shades of normality
and it would be impossible to single out one particular standard as representing a target of hypothetical normality.

2.5.2 Rights to Normality

The Scandinavian legislations (note 6) state three important rights consistent with more normal treatment of the retarded. First, the reception of a service is seen as a right. If there is a need for a service, there is a right to receive it, and only for the length of time that that need exists. Furthermore, there is a right for the provision of these services at home. Parents are not forced to choose institutionalization as the only option to home care. Second, schooling and education is seen as a right. Finally, there is a right to alternative accommodation; the medical-custodial model is not seen as being practical for all individuals.

Day (1976) argues that conventional and conformist lifestyles can be imposed on the mentally handicapped in the name of normality. The ability to make informed choice regarding services; or to comprehend and understand educational objectives; or to reside with other people in a "regular" society are necessary parts to rights as well as the ability to use them.

Goldberg (1975) discusses the problems encountered by some institution residents who "walked away" from the institution and wonders whether the retarded individual should be given "the right to have his day in court." Goldberg asks; "should one of the consequences of a court appearance be place-
ment on probation on condition that he be forced to return to an institution for the retarded?" Goldberg further suggests that the frequent reason for recommending many mildly retarded boys and girls into institutions is the dilemma regarding the right to marriage and sexuality of the retarded within the community. He then observes that the institutions have been placed in an untenable position regarding the hypocrisy of a society which espouses a normalized environment for the retarded, but at the same time excludes sexuality for them.

Goldberg (1975) then suggests that "Society should be cautious in the thrust towards de-institutionalization in order not to become anti-institutional. In the enthusiasm for application of normalization philosophies of treatment, we should not ignore individual rights and needs including the right to remain dependent." Ryan and Thomas (1980) agree by stating that "if the right to normality is not to become a whole series of pressures on mentally handicapped people to change and conform to other people's standards, then this right must include both the right and the means to question that normality and to live a different life, one that is an enrichment rather than a deprivation of normality."

2.5.3 Normalization Studies and Arguments

Although a firm empirical base for community-based and normalized services does not exist (Balla, 1976), there does exist a vast body of anecdotal and survey research (Birenbaum and Seiffer, 1976; McDevitt, Smith, Schmidt and Rosen, 1978)
as well as an increasing number of empirical studies using behavioral instrumentation (Close, 1977; Fiorelli and Thurman, 1979) which show generally favourable changes in resident behaviour after movement to community living arrangements.

In a review of the sociology of environments for mentally retarded persons, Tizard (1970) looked at factors within the organization of a facility which interfered with meeting the total needs of a person in that facility. Tizard concludes that a highly organized program would be antithetical to the normalization principle.

Advocates of normalization in general have not differentiated between the various levels of retardation which should be encouraged to live in as "home-like" an environment as possible (Goldberg, 1975). On the one hand, Clelland and Sluyter (1973) suggest what they term a "heterobedfast" environment which would be highly heterogeneous of all levels of persons with retardation and other persons who are immobile. Such an environment should be architecturally designed to stimulate and motivate both the residents and staff. On the other hand, Roos (1970) opts for the maximization of the retarded individual's control over his environment. However, Roos recognizes that perhaps, when given a choice, a retarded individual may reject the "normal" alternative in favour of a "non-normal" one. In such a case, the normalization principle would suggest denying the retarded person freedom of choice in favour of developing the "normal" pattern.
Goldberg (1975) notes that persons with borderline mental retardation have been eliminated from the definition of individuals who are mentally retarded by the American Association on Mental Deficiency (AAMD). He observes that this action did not automatically normalize the lives of persons with borderline mental retardation. Removing a label is one step, but if society or the community does not have a system in which to program or plan for all individuals, then such a step would accomplish very little (Kokaska, 1974).

Birenbaum and Seiffer (1976) pose the following questions: (a) what do people who cannot take care of themselves have in common with other human beings? (b) Under what social conditions are these common human characteristics fostered and sustained, and other less desired characteristics modified or made less obtrusive?

Mesibov (1976) responds to these questions by noting that normalization is not easily measured or validated; is not oriented toward individual clients; does not represent an enduring value system; and does not deal with the basic differences between retarded and non-retarded citizens. He argues that normalization does not necessarily improve public attitudes towards retarded citizens "simply by putting people together." Mesibov describes a recognized evaluation tool for normalization developed by Wolfensberger and Glenn (1975) as simply measuring conformity of service systems to normalization principle; and regards the real issue as the effect
of these systems on the individuals they are designed to serve.

Rhoades and Browning (1977) went further to suggest that normalization may be of disservice to the common interests of the mentally retarded. They believe "the field may be caught up in a movement which has the potential of inadvertently denying the retarded person the opportunity to build an important type of meaningful peer relationship." They also observed that often persons who are labeled "deviant" deliberately seek out personal contact with those with whom they share a common exceptionality which encourages self help organizations.

The most forceful critique of the principle of normalization is provided by Thorne (1975), who argues that treating the mentally retarded normally will leave them functioning as retarded. "Retarded by definition means retarded under ordinary conditions. Only extraordinary conditions normally can result in diminishing retarded states, i.e. making the retarded more normal." He then concludes that "generalized application of both the normative procedures of the normalization principle and of procedures of treatment, training or teaching that are specialized, is logically contradictory."

The review of the literature on normalization reveals opposite views and arguments. This is probably due to the philosophical rather than empirical base on which it stands.

2.5.6 Dimensions and Implications of Normalization

Outlined below are the dimensions and implications of
the normalization principle, presented in four general categories (Wolfensberger and Glenn (1975): (a) Non-deviant social interpretations; (b) non-deviant structures; (c) social and physical integration; and (d) provision of human rights. These dimensions and implications have been used as the basis for the design of this study.

Non-deviant social interpretations refer to certain elements which are culturally interpreted by society as being deviant, and thus increase the retardates stigma. To achieve integration at a functional level one must not only normalize the presentation of the retardate but also normalize the perception of society. For example, labels which suggest deviancy such as "Retarded Adults Workshop" increase perceived deviancy. The appearance and history of a building can increase community perception toward deviancy. In the physical context, a setting should be close to socially integrative physical resources and a facility must also be in a location consistent with its function, for example, workshop should be in an industrial area. Manpower identity must be appropriate to the needs of the people served. For example, medical personnel operating or supervising a residential facility would increase perceived deviancy.

Non-deviant structures relate to the structure of a program in a fashion consistent with the persons age level, rather than some deviant role model. While structures also affect social interpretation of the person, they also directly
affect their behaviour, thus increasing the degree of perceived deviancy (Vail, 1967). The internal and external appearance of the facility must be appropriate for the age of the person served. He or she should have a right to personal possessions and engage in age-appropriate activities (Nirje, 1969).

Social and physical integration relate to opportunities for contact, both in the physical and in the social sense. A physically integrated setting allows for, or even facilitates social integration and thus maximizes a person's participation in the mainstream of society. Physical integration allows for the following dimensions: (a) proximity to community services and to the main distribution of the population, (b) access in terms of speed and convenience to transportation routes enabling closer contact to the public, and (c) dispersal in terms of not congregating retarded people in larger numbers than the surrounding community can absorb or integrate. There should be regular opportunities for normal integration in the following areas: Residence, Recreation, Social interactions - e.g. worship, shopping and routine aspects of living - education, training or work. There should be integration of generic services aimed at serving citizens in general rather than a specific disability group. Most services such as health, education, welfare or employment could be delivered to all people through generic services.

The provision of human rights relate to all rights which
are available to all citizens such as legal rights to vote, own property, testify and stand trial or to engage in legal contracts. The right to education and choice of work as well as sexual and marriage rights are considered important aspects of normalization.

In pure forms, these dimensions and implications of the normalization principle raise several questions. For example, is the society sufficiently ready to accommodate the rights of the handicapped even though it may infringe on the right to remain separate or different? What is the attitude of the community towards the mentally retarded? Does the implementation of these rights require additional financial burden to the society? Are society's institutional mechanisms sufficiently flexible for the accommodation of these rights?

Menolascino (1977) outlines ten ways by which normalization principle can be asserted. These ways are essentially similar to the dimensions of normalization which have been described above. However, Menolascino emphasizes that even the most severely retarded person should be provided with the opportunity to engage in work that is culturally normal in type, quality or setting, and that services should meet the same standards as other comparable services and facilities for the non-retarded - not be stricter nor lenient.

2.6 Community Adjustment of De-Institutionalized Mentally Retarded Adults

The major findings in the literature that relate to the
community adjustment of previously institutionalized mentally retarded adults are as follows: (a) There is no consistent relationship between age at the time of release and community adjustment. McCarver and Craig (1974) found no significant relationship in either direction following a review of twenty-four studies; (b) the length of institutionalization may be a favourable indicator for custodial types of placement. Windle (1962). However, a number of researchers have reported no significant relationship between length of institutionalization and outcome in the community. Clark et al (1968), Edgerton (1967); (c) there is a consistent lack of relationship between diagnostic category (organic versus cultural familial) and adjustment (Heal, Sigelman and Switzky, 1978); (d) while intellectual level has been analysed in numerous studies, most studies have found no meaningful relationship. Studies supporting a position relationship are also numerous (McCarver and Craig, 1974; Heal et al, 1978). Some studies found that the more retarded are more likely to remain in the community compared to the less retarded as they have fewer needs (Gollay, 1976); (e) personality appears to be related to community adjustment although the evidence is not extremely strong; (f) personal appearance is positively related to success in three of four studies, the presence of physical handicaps bears no consistent relationship to outcome (Heal et al, 1978); (g) vocational skills appear to be somewhat associated with community success (McCarver and Craig, 1974); also social skills were
significantly related to success in five of six studies in which they were examined.

2.7 The Retarded Adult in the Community

Studies of retarded adults in the community have been contradictory in their findings. However, the following picture tends to emerge.

A large majority of mentally retarded persons tend to function in smaller less structured, more normalized community settings. Nihira & Nihira (1974, 1975).

There is a higher prevalence of maladaptive behaviours in institutions when compared to community settings. Higher functioning retarded persons defined by level of retardation exhibited less maladaptive behaviour than lower level functioning residents (Cohen et al, 1977). Also, I.Q. has been positively correlated with legal problems. Persons with mild and borderline levels of retardation encounter the most number of incidents (Bell, 1976). However, some studies relating client adaptation after placement into community-based residences from institutions indicate that deinstitutionalization is not living up to expectation (Conroy, 1977). In general, it is the occurrence of maladaptive behaviours that account for a significant portion of the variance in predicting community adjustment.

Environmental variables such as the emotional attitudes of caretakers are important to client success. Community
placement is contraindicated if the community lacks supportive services or shows evidence of misconceptions about mental retardation (Sutter, 1980). The success or failure of placement was defined as the return to the institution of previously institutionalized retarded individuals within one year of community placement.

Also, homes in which additional family members lived had significantly higher failure rates than homes in which there were no relatives. On the other hand, homes which had lower failure rates, had significantly more relatives living nearby (Sutter, 1980). In general, the system of support available to the caretaker and client might be the most important factor in determining whether a retarded person remains in the community and receives assistance, or returns to the institution (Crawford, Aiello and Thompson, 1979).

Retarded persons who were not successful in their initial competitive job placements were more likely to have a secondary emotional disability than those who were successful in their placements (Fulton, 1975).

Training in social skills has been shown to correlate with community placement of mentally retarded adults (Stacy, Doleys and Malcolm, 1979). Most important is the finding by Eyman et al (1979) that some of the principles of normalization are related to the level of social development of retarded individuals. However, they also found that in general, older, less retarded residents improved in overall
adaptive behaviour "regardless of where they lived." On the other hand, Eyman and Call (1977) found a much higher prevalence of behaviour problems in the institutions as compared to community placements; also that profoundly retarded individuals, unless handicapped by not being able to move around, exhibit more injurious behaviour than mildly retarded persons.

In an extensive categorization of reasons for success or failure in community placements, Moen et al (1975) found that the most common reasons for failure are behaviour oriented rather than medically oriented. The opposite line of argument has been used by opponents of normalization and proponents of the clinical perspective to advance the continuation of institutionalization.

Transportation, finances and program planning are three causes that plague the development and the extension of leisure activities for retarded adults (Corcoran & French, 1977).

In summary, successful independent living is related to personal maintenance, clothing care and use, socially appropriate behaviour, demonstrated skills in symbolic operations and to some extent on the level of intelligence. Return from community placement to the institution is related to money management, cleanliness, social behaviour, and meal preparation (Shalock & Harper, 1978). McCarver and Craig (1974) suggest that one reason for decreasing success rate in recent
years may be the increasing complexity of society. They also noted that the ability levels of institutional population has gradually decreased over the years, and thus, a higher rate of community failure may be attributable to these ability factors. However, the term social behaviour covers a number of variables such as personal characteristics, emotional stability and social skills which renders it a difficult subject to study. The frustration and contradictions of several studies and the governments' slow response to the needs of the retarded adult has prompted some to observe that "Community Care has no specific meaning at all. Every function exercised by any kind of government on behalf of or for the benefit or protection of the inhabitants of any state is definably community care. .... As in all bureaucracies, change takes place at the speed of the Mills of God." (Gittins, 1978).

However, there seems to be an agreement that successful community care and of the process of deinstitutionalization depend largely on the continuity of care and the existence of appropriate community services for even the most difficult client (Eyman & Borthwick, 1980). In this regard, the nature of community attitudes has been one of social ambivalence (Eyman, Meyers & Tarjan, 1973). On one hand there is a sense of fear and threat to major social institutions which is generated by the very existence of the incompetent. On the other hand there is a climate of sympathy and a willingness to accept the retarded within the community and to assume responsibility for his care and habilitation. These opposing
stances lead to alternative status and role assignments, differing programs, and a situation of social ambivalence.

2.7.1 The Nature of Community Services

Scheerenberger (1974) provides a comprehensive model for community services. He describes those services which must be available and those which should be available, and contrasts these with Residential Services.

Community Services which must be available are: (a) Adequate home-like environment, such as natural home, foster home, group home, nursing home, and independent living-facility; (b) health services; (c) education and training; (d) employment - open and sheltered; and transportation.

Community services which should be available are: (a) Recreational; (b) Religious; and (c) All other services available to any citizen, e.g. commercial, welfare, family counselling, and protective services.

Scheerenberger regards the services which should be available as very essential and cautions that most residential facilities should function as Regional Centres, offering specialized and short term services and programs, and specialized back up and consultancy services. He further defined "Community" as "a social group of any size whose members reside in a specific locality, share government, and have a common cultural and historical heritage," or "a general population having a common interest or interdependency in the
delivery of services." He conceptualizes the interrelationships of communities as comprising of the individual's community and the residential community within the socio-political community, all contained in the larger societal structure.

He makes the strong point that the community that is available to the retarded should offer "the least restrictive environment." He then defines four integrants to effective community programming as the setting of standards by a monitoring agency, back-up services and support, adequate financial resources, and legal advocacy system. These integrants should mediate between the Community and the Residential facilities.

Menolascino and Eaton (1980) provide a hierarchy of residential options according to their degrees of restrictiveness; from the least restrictive to the most restrictive in the following order: (a) Primary home or independent living; (b) living with family or relatives; (c) foster care; (d) small alternative living units; (e) group homes; (f) residential care facilities - supervised; (g) intermediate care facilities - skilled medical supervision available; (h) community-based nursing homes; (i) small congregate care institutions (Regional Centres); (j) large congregate care institutions (Provincial hospitals).

Menolascino and Eaton suggest that the Community-based
system of service must begin near the middle of the scale with group homes, but to meet the varied needs of retarded persons, the system should provide a continuum of residences that encourage the self sufficiency of the individual. They observe that residential systems, by and large, have remained stuck at the 'group home' concept for much of the 70's. They also anticipate a future shift from "the professional knows best" position to one of shared parent/adult/professional decision making, and increased recognition of the rights of the handicapped.

Heal, Sigelman and Switzky (1978) developed a taxonomy of Community Residential Facility, CRF, alternatives as follows: (a) Group Homes which are differentiated from each other according to size and nature of occupants; (b) Protected environments such as nursing homes, foster family care and sheltered villages; (c) Training Programs such as workshop dormitories in which the living units, serving retarded adults is associated with a sheltered workshop; and (d) Semi-independent units in which less than 24 hours supervision is provided.

2.8 The Needs of the Retarded Adult

Armour (1979) describes the needs of the retarded adult as, in many respects, similar to the needs of all beings. These are material, psychological and social needs.

Materially, all being have a need for food, shelter,
warmth and comfort, money, facilities to preserve health, clothing, transportation, and a bit of territory. On the psychological side are the needs for security, satisfaction, accomplishment to feed the self esteem, enjoyment and fun, company and affection, training and education, sexual satisfaction, and advice and counselling. The social needs include protection and legal rights, the provision of some other necessities such as essential services - transportation, health care and education. There is also legal need for those who may need it.

Bush (1977) surveyed the needs of the intellectually handicapped and their families in New Zealand, and came to the conclusion that the care and needs of each intellectually handicapped person should be appropriate to that person's individual requirements. These requirements change throughout the person's life.

This conclusion is consistent with that of Zipperlen (1975) in the United States with respect to the need for individualized problem-solving.

2.9 Summary

The above review of literature regarding the issue of mentally retarded adults in the community and the social policy of normalization reveals the following important aspects: (a) The varied concepts and meaning of mental retardation influence the type of care that is provided in a given society.
(b) Institutional and professional activities enhance labeling and deviant perceptions in the society thus leading to the development of social mechanisms for the containment and control of retarded persons. More importantly, the "deviant-izing process" is regarded as a key factor on how a society perceives the mentally retarded in their midst. The position that has been taken in this study is that the carry-over of deviant labels and deviant structures from institutions for the retarded to the community leads to deviant-type community services. (c) Normalization is a change process away from deviant role perceptions and which challenges established social norms and raises questions with respect to rights and privileges. Normalization process may be viewed as leading to a conformity model of society. The key aspect of normalization is not necessarily on outcome, but such processes as non-deviant social interpretations, non-deviant structures, social and physical integration, and the provision of human rights. (d) The arguments and literature findings on issues regarding de-institutionalized retarded adults in the community, are in most parts, contradictory. There is little or no information which relate to the individual needs of retarded adults in the community, as opposed to their collective needs. More importantly, there has been no study of which the author is aware, which relate individual community service needs to the principle of normalization.
CHAPTER 3.0
CONCEPTUAL AND METHODOLOGICAL GUIDELINES

The purpose of this chapter is three fold: to describe the various theoretical and methodological guidelines in order to demonstrate the manner in which they serve as the source of conceptual and analytical frameworks used in the study; to relate these frameworks to the data base which is the focus of the study; and to present the design by which the study is carried out.

The theoretical and methodological guidelines used in the study have come from the disciplines of education (Kerr, 1976a, 1976b; Dworkin, 1977), Social Sciences (Wolfensberger, 1972, Gil, 1976) and Medicine (Kessner et al, 1973; Brook & Appel, 1973).

3.1 Policy Concept

In Chapters 1.0 and 2.0, "normalization" has been variously referred to as principle or policy. Dworkin (1977) separates the two by stating as follows:

I call 'policy' that kind of standard that sets out a goal to be reached, generally an improvement in some economic, political or social feature of the community ....... I call 'principle' a standard that is to be observed....because it is a requirement of justice or fairness or some other dimension of morality.

Thus, a distinction is drawn between policy and principle, the former being descriptive of goals, the latter of rights.
Legally, arguments of policy justify a political decision by showing that the decision advances some collective goals, while arguments of principle justify such a decision by showing that it respects some right (Dworkin, 1977). In the legal sense therefore, either a principle or a policy may be used as justification for a decision.

Kerr (1977a) takes the view that when a decision regarding what is to be done is yet to be made, it would seem more correct to say that a principle has been adopted for which a policy might be decided.

The distinctions drawn by both Kerr and Dworkin appear to hinge on the specification of conditions. Dworkin (1977) notes that a principle does not set conditions; it provides a reason for a particular argument. Kerr's example suggests that the evolution of a principle into policy form requires selection from a number of actions which individuals may choose to perform in a given situation and that the selection itself should support the "reason," that is, the principle.

It may be argued that in Kerr's example, what is stated is a policy, behind which lies the principle of equity. However in using the framework which this study adopts, Kerr's definition of policy, as "a category of action" will be adhered to, and therefore "policies" are taken to be statements which specify, more exactly than principles, intent, direction and action. A further distinction to be kept in mind is that one might appeal to a principle to justify a policy.
Thus, a principle is seen to be of a higher, more generalized order than a policy and can be thought of as a fundamental belief about, or stance towards, a particular constituency. It is in other words, a value orientation.

However, some inconsistencies occur in the manner in which policy and principle are authoritatively defined. In legal terms, for example, Black (1968) defines policy as the general principles by which a government is guided in its management of public affairs, or the legislature in its measures. The legal notion of policy, therefore, refers to the probability that what is effected in law will enhance social well-being. Thus, there is a protective factor in legislated policy in that it purposefully seeks to maintain the social good. This legal definition points to overlaps in definitions of policy and principle; however, and in so doing aid in definition, that policies may be justified by appealing to principles.

3.1.1 Policy Analysis

Kerr (1976a) looked at educational policy and specifies four policy conditions which serve to distinguish policy from related concepts. These are:

Condition 1. Some authorizing agent (Aa) obligates itself to direct some implementing agent (Ai) to act in accord with some specified conditional imperative (I).

Condition 2. The conditional imperative (I) must be of the form to do something which counts as some specified
X-ing whenever, without exception, specified conditions (C) occur.

Condition 3. The authorizing agent (Aa) undertakes the obligation (condition 1) for the purpose of effecting some specified state of affairs (S) and to do so without violating any restrictive rules (R) by which (Aa) would claim to abide.

Condition 4. The authorizing agent's obligation can be revised and yet not be violated both if the authorizing agent announces his revision of the conditional imperative from 1 to 1' to those persons who can bring about conditions C and C' and if the authorizing agent gives consideration due the views of the relevant public as defined by the political and moral contexts of the initial policy decision and its revision.

If Kerr's four conditions are met for any particular statement, therefore, what we are dealing with is a policy, rather than a principle, a plan, a programme, or any other number of concepts which might, without some means of differentiation, be mistaken for a policy.

In this study, the operational definition of "policy" (Chapter 1.0 p. 49) has been segmentalized into two components; (a) principle and (b) policy. For the purposes of analysis, principle will be regarded as a fundamental value orientation which may justify a policy, and policy as
one category of actions which is planned and undertaken with particular purposes in mind. Social policy, therefore is a policy which has a social purpose, and legislated policy, that (social or medical) policy, the source of which is enacted legislation.

Further synthesis of policy analysis has been provided using Gil's (1976) framework for policy analysis. Gil specifies that analysis and linkage of policy and data may be achieved through: descriptive analysis of the issues dealt with by the policy; analysis of the implications of policy for distributional processes; and the evaluation of the correspondence between the consequences of policy and the general requirements of the community or society for development of services, or between value positions.

3.2 Normalization Concept

In Chapter 2.0, it has been shown that normalization is culturally relative (Wolfensberger, 1972) and that there are few studies which are directed towards normalization; and that studies relating to retarded adults living in the community are often contradictory.

Butler and Bjaanes (1977) addressed the question of whether living in a community facility is qualitatively superior to living in an institution, and found that there is very little basis with which to indicate that community residential facilities actually have a positive effect. They
concluded that different types of environments result in different kinds of normalization. Their findings are supported by Edgerton (1976) who finds that the quality of life in alternative community residences varies considerably from one setting to another.

This study therefore takes the position that the operational definition of normalization will have to relate to the study environment or community, in this instance, the Greater Vancouver Region of the province of British Columbia (Appendix A). The methodological procedure is further described in this chapter.

Three of the four dimensions of normalization (Chapter 2.0) identified by Wolfensberger and Glenn (1975) have been used to develop five criteria for the measurement of normalization (Appendix A). These are: non-deviant social interpretations; non-deviant structures; and social and physical integration. The fourth dimension, provision of human right has not been measured.

Non-deviant social interpretations and non-deviant structures are taken to relate to the name, nature, and type of service which is being made available. Social and physical integration as well as non-deviant structures have been taken to relate to the location of a service and the amount of integration that the service provides for retarded and non-retarded adults.

The operational definition of normalization is therefore,
that interpretation of normalization which has been given within the Greater Vancouver area of British Columbia. From this interpretation the criteria for the evaluation of normalization content in community services is developed to cover three of the four dimensions of normalization suggested by Wolfensberger and Glenn (1975).

3.3 Needs and Services

In Chapter 1.0, p. 49-50 need is defined as an individual necessity - social, medical, psychological, vocational, educational, recreational or residential - which has been identified by a team of care givers at Woodlands at the time the individual is discharged to the community. Consequently, in this study, areas of need as listed above are the same as the areas of service, the rationale being that need occasions service, if there is not a need, then there will not be a service.

The idea is, by following needs which have been identified, to community services which have been used to address them, one will relate needs to services. By subsequently measuring the normalization content of these services using a set of criteria a link will be provided between the data base and the conceptual framework.

3.4 Design of Study

The nature of the study requires some means with which to define normalization in the area of study. Having defined normalization, it will therefore be necessary to establish
some criteria with which to measure the different aspects of the definition as well as the manner for gathering data and maintaining the various relationships of the study.

3.4.1 Determining normalization in Greater Vancouver Region

Brook and Appel (1973) developed a method for quality of care assessment in medical care in which they used the implicit and explicit judgement of peers.

Implicit judgements rely on the subjective opinion of individual judges and no pre-determined criteria are used. Explicit judgements rely on pre-determined criteria set by group agreement.

Brook and Appel (1973) find that Implicit-process judgement and explicit-process judgement are accurate in better than 65% of the criteria used; whereas implicit-outcome judgement is less reliable. For implicit judgement, Brook and Appel used random sample of professionals (in this instance physicians) in the hospital under study. Explicit judgement involved the use of outside (physicians) professionals who were not working in the hospital under study. They obtained more reliable and valid results with measurement of process than with measurement of outcome.

This study therefore utilizes implicit and explicit judgements in determining what is considered as "normalization of service" in the Greater Vancouver Region. The study is based on the premise that the policy of normalization
leads to a better quality of care or better quality of service in the community. In other words, high levels of normalization lead to high levels of quality of care or service. Therefore, the study is a process study which assumes that a measure of process is an indirect measure of quality.

In Chapter 2.0, it has been discussed that there are different interpretations of normalization. The discussion on labelling and deviance indicates that there exists a professional and non-professional points of view regarding the care of mentally retarded persons. In Chapter 1.0 it has been shown that advocate and volunteer groups perhaps entertain relatively wide views of normalization relative to professionals in the field. A third point of view may be entertained by a citizen who is neither a professional in the field or mental retardation nor an advocate for the mentally retarded.

In order to define normalization in the study area, it is necessary to consider the three possible points of view. This is achieved by a combination of implicit and explicit process judgement which has been provided by professionals in the field of mental retardation who are involved in specific services under measurement; and citizens who have been randomly chosen from the telephone directories and who are not providing service in the field of mental retardation.

There are two groups of professionals: (a) Those professionals who are working in government service or institutions for mental retardation (in this instance, Woodlands); and (b)
those professionals who are working outside of government service. The first group are assumed to be the interpreters of policy directives while the second group of professionals may be reasonably assumed to be implementors of policy which has been directed to the community.

In order to answer the question: "What constitutes normal treatment for the mentally retarded in Greater Vancouver area of British Columbia?" a list of professionals from each of the seven areas of service (Section 3.3) is compiled from staff directory of the Ministry of Human Resources in the study area, and another list of professionals is compiled from professional Association directories in the same area. The table of random numbers is used to obtain two professionals in each list. A total of 28 professionals are obtained for the seven areas of service. In other words, there are two professionals for each area of service, for example two psychologists working in government service and two psychologists working outside of government service. 14 citizens were randomly obtained from the telephone directories of the Greater Vancouver area. Subjects were contacted by telephone, letter or personal contact in order to obtain their agreement to participate in defining normalization (Appendix A).

A panel of three "judges" for each of the seven areas of service was set up as follows:

1 professional member from government service,
1 professional member from the community and outside of government service,
A second panel of 'judges' was similarly set up to provide a measure of reliability of responses.

Each panel member was then presented with: (a) a simplified definition of mental retardation, (b) an exact literature definition of normalization principle as given by one of the originators of the principle (Nirje, 1969) and (c) exact government policy statements regarding normalization principle as policy in British Columbia. (Appendix B). Immediately following these statements are three pairs of statements (A, B, C) which describe various levels of treatment and/or service and which have been developed from different literature interpretations of normalization principle. (Appendix B). Each pair of statements represents a level of normalization as follows: A, Normalizing; B, Subnormalizing; and C, Least Normalizing or Deviant process. (Appendix B).

Each judge working in isolation, was then asked to check off (√) one sentence in each pair of sentences according to his or her understanding or perception of most normalizing, subnormalizing or least normalizing sentences.

Two of the three judges must check off the same sentence in order for that sentence to be used as measurement criteria. One of the two judges must be the citizen member of panel in order not to obtain an entirely professional judgement. To validate the results, a second panel of judges, similarly composed, was asked to check off the sentences. Agreement
between the two panels of judges was then examined.

The definitional sentences for each area of service which has been obtained from the implicit and explicit judgements are used to develop measurement criteria for each service, (Appendix C). Community services are then scored as follows; 3 for normalizing or therapeutic service; 2 for sub-normalizing or maintaining type of service; and 1 for the least normalizing or custodial or deviant service. The various criteria for each of the three categories are given in "Measures of Services" (Appendix C).

3.4.2 Organization and Design

The hypothesis requires that the study population be organized in two groups (Chapter 1.0). Group A comprises of mentally retarded adults who had been discharged before the introduction of the normalization policy by the provincial government. The period from January 1, 1969 to December 31, 1973 has been regarded in this study as the "pre-normalization period." This period also relates to the medical model of care when the Ministry of Health had the responsibility for mental retardation. In 1975, the Ministry of Human Resources assumed responsibility for mental retardation services. Therefore, the period from January 1, 1974 to December 31, 1975 is regarded in this study as the period of transition, and no data relating to this period was gathered.

The period from January 1, 1975 to December 31, 1979 is
therefore the "normalization period." Thus the study covers five years before and after the introduction of the policy of normalization.

The design used in gathering data has been adopted from Kessner, Kalk and Singer (1973). Kessner and his colleagues used what they call "Tracers" in assessing the quality of health.

The tracer concept is borrowed from formal sciences and medicine where radioactive tracer elements are injected into the body and followed as they come in contact with various body organs to measure how these organs take up minute amounts of elements. Thus, tracers are used to shed light on how particular parts of a system works, not in isolation, but in relation to one another.

In this study, the tracer concept has been used to identify and follow the individual needs of retarded adults from the institution to community services. (See Chapter 4.0 for more detail).

Kessner and his colleagues specify certain conditions which are necessary for use of tracer method. These are: (a) A tracer should be relatively well defined. This has been achieved by the use of needs as tracers and defining individual needs as specific for certain service categories. For example, a residential need involves living in a family house, a hostel, a group home or an institution; (b) the
prevalence rate should be high enough to permit the collection of data from a limited population sample. This study uses the entire population as defined by set boundaries and avoids the use of sample. Moreover, the number of subjects in the study has been deemed high enough to meet this requirement; (c) the natural history of the situation should vary with utilization. Each of the study years has experienced discharge of retarded adults from Woodlands to the community, for which community services have been provided; (d) the techniques of management should be well defined. There are set guidelines with respect to how a given service is to be provided; and (e) the effects of (non-social) other factors on the tracer must be understood. Some of the factors which may affect how an individual's need is met in the community have been identified in Chapters 1.0 and 2.0. Some of these are public attitude, advocacy, professional input, family relationship, and bureaucratic delays.

Using the tracer concept, the individual needs of previously institutionalized mentally retarded adults are identified at Woodlands from records, and traced retrospectively to the community services which have been used to address these needs.

3.5 Summary

In this Chapter, conceptual and methodological guidelines have been discussed.

The concepts of Policy and of principle have been
differentiated. Also, the framework for the analysis of policy as well as the components of policy have been presented (Kerr, 1977a, Gil, 1976).

The four conditions of policy outlined by Kerr (1977a) are regarded as essential in making a distinction as to what constitutes policy (a category of actions) and what constitutes principle (the reason for actions).

In order to define "normalization," in the study area, implicit and explicit process judgements have been used (Brook and Appel, 1973), to develop measurement criteria for community services.

The organization and design of the study has been described as involving the grouping of the subjects into pre-normalization and normalization categories as dictated by the requirements of the hypothesis; and the utilization of the tracer concept (Kessner et al, 1973) in procedure.

Details of procedure and methodology are described in Chapter 4.0.
CHAPTER 4.0
PROCEDURE AND METHODOLOGY

In Chapter 1.0, the problem of the study is presented in the form of research questions (1.6.4) and three sets of research hypotheses (1.6.5) concerning the relationships between services which have been made available to previously institutionalized retarded adults before and after the introduction of normalization policy, their needs, and the nature of normalization content in the services. In Chapter 2.0 a review of the literature is presented to acquaint the reader with existing studies and discussions relevant to this problem. Chapter 3.0 discusses the conceptual and methodological guidelines used in the study. In the present chapter, the procedures and methodology used in conducting the study are described.

4.1 Limits of Study

The subjective nature of the concept of normalization, necessitate the setting of limits and reference boundaries. The particular areas in question relate to population, geographic boundary, period under study, and limits of assumptions.

4.1.1 Population

The study population comprises of the following persons:
(a) All mentally retarded adults - male and female - between 19 and 40 years of age, inclusively, who had been institutionalized at the provincial institution for mental retardation; Woodlands, at New Westminster. (b) All persons as described
in (a), but who must have resided at Woodlands for at least 12 months continuously before discharge or placement in the community. The last continuous period of institutionalization is used irrespective of the number of previous admissions to Woodlands. (c) Subjects, who, while meeting the specifications in (a) and (b) must originally have been admitted to Woodlands from the Greater Vancouver area of British Columbia. (d) Subjects must also have lived continuously in the community for a period of 12 months at least and have continued to live outside of Woodlands. Subjects who had been transferred to Eric Martin Long Term Care Facility in Victoria were excluded for reasons of inaccessibility.

4.1.2 Area Under Study

The study area is limited geographically to the Greater Vancouver Regions of British Columbia. The area is made up of the following towns: (a) City of Vancouver, (b) North Vancouver, (c) West Vancouver, (d) Burnaby, (e) New Westminster, (f) Surrey, (g) Richmond, (h) Delta, (i) Coquitlam and (j) Ministry of Human Resources administrative Regions within these towns.

4.1.3 Periods Under Study

The study period is divided into two. The first period is between January 1, 1969 to December 1973 - a five year duration - when the Ministry of Health had the responsibility for mental retardation and which has been designated as involving the medical/custodial model of service (Chapter 1.0,
This period has been regarded as the pre-normalization period. Subjects who had been discharged or placed in the community during the pre-normalization period have been designated as Group A in this study.

The second period is the five year duration between January 1, 1975 and December 31, 1979 when the Ministry of Human Resources assumed responsibility for mental retardation under a policy of normalization of services. This period is regarded as involving a social model of service and has been designated as the normalization period (Chapter 1.0, pp. 28-35). Subjects who had been discharged during the normalization period have been designated as Group B in this study.

The period between January 1, 1974 to December 31, 1974 is regarded in this study as a transition period when administrative adjustments were made by both the Ministry of Health, and the Ministry of Human Resources.

With regard to empirical data, only the 12 months immediately following the discharge of a subject from Woodlands institution has been considered.

4.1.4 Assumptions and Limitations

In conducting the study, it has been assumed that institutional records at Woodlands provide approximate indication of places of residence for all subjects admitted to the facility. Therefore it has been assumed that all subjects whose records indicate as having been admitted from the Greater Vancouver
area of British Columbia may therefore be regarded as originally residing in the area. Consequently, the specific town, village or area is the individual's local community. It is possible that a few admissions have been made for subjects who temporarily resided in Greater Vancouver area, or who are in the area specifically for admission purposes.

The age limits 19 to 40 years has been used for two reasons. The first is that this age range is conceivably the most active and productive period in life when several demands may be made on an individual by way of independent living, employment and socialization; and on the system by way of services other than dependency services. Therefore, if one intends to look at a range of community services, one would have to consider several factors which provide independence rather than be limited to more of dependency factors or long term care. The second reason relates to difficulty in tracing all deinstitutionalized subjects who may, over the years, have either died, relocated to other parts of British Columbia or have simply transferred to another province. The inclusion of all adult subjects would have severely strained the financial and personal resources available for this study, especially since the methodology calls for the tracing of individual subjects and needs to various community services.

It is also assumed that a 12 month post deinstitutionalization period is sufficient for the determination of the relationship between needs and services as well as the content of normalization in services. In this study, only the 1 year
immediately following discharge of a subject has been considered. It is however recognized that individual needs may be re-determined, increased or decreased over years of community living. This would have created design problems since subjects who had been discharged much earlier in the period under study may conceivably be involved in a myriad of services as their needs change, more than those adults who had been discharged later in the period. Also, it is necessary to have a common factor rather than factors for the study population. This has been achieved through specifying that only the immediate 12 months following community placement would be considered. This is the period when there is apparent or real urgency to stabilize community living.

4.2 Procedure

Three stages of procedure which had been considered necessary for data collection are identified (Fig. 1).

The first stage involves the definition of normalized services within the geographic boundary of the study, as well as the development of measurement criteria and a scoring system.

The second stage relates to the specification of study population from institutional records, the specification of individual needs, and the grouping of subjects.

Individual needs are linked to community services during the third stage. Community records are examined and where necessary, officials are interviewed in order to specify
STAGE I
Normalization
(Community)

- Determine Geographic Boundary
- Define service normalization within study boundary - explicit and implicit judgement -
- Develop measurement criteria and scoring system from definition of service normalization for each service/need area.

STAGE II
Needs
(Institution/Woodlands)

- Determine study population from institutional records.
- Define Individual needs as given from institutional records.
  - pre discharge needs -
- Group subjects for pre and post normalization community placements and by sex.

STAGE III
COMMUNITY
(Needs/Services)

(a) Link individual needs to services.
(b) Apply normalization criteria to services and score.
(c) Interview workers where necessary or examine community records.
(d) Analyse linkage between Normalization and Services; and Needs and Services.

Fig. 1 Schematic Diagram of Study Procedure
services or data. Services are then scored using the criteria which had been developed in stage one.

4.2.1 Stage I

The procedure and method used in determining what could be regarded as normal service for each of the seven areas of need in Greater Vancouver area have been described in Chapter 3, subsection 3.4.1 (pp. 111-115). As has been indicated in Chapter 3.0, the table of random numbers was used to obtain two professionals in government service and two professionals in non-government community service for each of the seven areas of needs/service (p. 113). In this manner, a total of 28 professionals were obtained from a list of professionals in each service area within the Greater Vancouver Regions. The Staff Directory of the Ministry of Human Resources was used to compile a list of professionals in Government service for each of the need/service areas. A second list was compiled from appropriate professional registers and from which the professionals within the study area were obtained. The telephone directories for the study area were used in random selection of 14 citizens. Agreement to participate in study was obtained either by mail (appendix B(i)), by telephone, or by personal contact during the period when postal workers were on strike.

A panel of three judges for each service was then constituted to comprise of two professionals with knowledge of the particular service area - one from government service and one from the community or non-government service - , and
one citizen. A second panel of judges was similarly constituted to validate explicit and implicit judgements that had been made by the first panel of judges. Explicit judgement refers to the input provided by the non-government worker. Implicit judgement of criteria refers to the input provided by the professional who is employed in government service. In order to avoid an entirely professional input, one citizen input was added. The citizens in these instances were those persons randomly obtained from the telephone directories but who neither work in the field of mental retardation nor are associated with someone who is mentally retarded.

Judges were then provided with a simplified, non-biasing definition of mental retardation (appendix B(ii)); a text book definition of normalization as given by one of the originators of the concept (Nirje, 1969); and selected but exact government's policy statements which have been obtained from the Ministry of Human Resources Annual Report of 1975 (appendix B(ii)).

Judges were then asked to read these definitions and statements before checking off (v) one of a pair of statements which describe normalized, subnormalized, and least normalized services for each service area (Appendix B). These statements have been constructed from different ideas regarding normalization (Chapter 2.0) and from published government guidelines and regulations regarding the delivery of community services.
for mentally retarded persons.  

Three judges - two professionals with expertise in the particular service, - and one citizen, form a panel for each service category. A second back up panel, which has been similarly comprised was asked to judge the statements as well. As indicated in Chapter 3.0, agreement by one professional judge and the citizen was sufficient for the particular statement to be used as criterium for measuring an aspect of service. Where two of the professional judges agreed and the citizen disagreed with them, the judgement of the back up panel was used provided the citizen in that panel was in agreement with at least, one of the judges.

<table>
<thead>
<tr>
<th>Service</th>
<th>N</th>
<th>SN</th>
<th>LN</th>
<th>% P₁</th>
<th>% P₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td>A(i)</td>
<td>B(i)</td>
<td>C(ii)</td>
<td>83</td>
<td>100</td>
</tr>
<tr>
<td>Social</td>
<td>A(ii)</td>
<td>B(i)</td>
<td>C(i)</td>
<td>67</td>
<td>83</td>
</tr>
<tr>
<td>Psychological</td>
<td>A(ii)</td>
<td>B(i)</td>
<td>C(ii)</td>
<td>83</td>
<td>83</td>
</tr>
<tr>
<td>Educational</td>
<td>A(i)</td>
<td>B(i)</td>
<td>C(ii)</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>Vocational</td>
<td>A(i)</td>
<td>B(ii)</td>
<td>C(ii)</td>
<td>100</td>
<td>83</td>
</tr>
<tr>
<td>Recreational</td>
<td>A(i)</td>
<td>B(ii)</td>
<td>C(i)</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Medical</td>
<td>A(i)</td>
<td>B(i)</td>
<td>C(ii)</td>
<td>67</td>
<td>83</td>
</tr>
</tbody>
</table>

Table 1 Implicit and Explicit judgement of normalization of services and percentage agreement by professionals

N = Normalization
SN = Subnormalizing
LN = Least Normalizing or Deviant
P₁ = Percentage agreement for implicit judgement
P₂ = Percentage agreement for explicit judgement
A = Normalizing Statement
B = Subnormalizing Statement
C = Least Normalizing Statement

(Appendix B(iii) - B(ix)

Table 1 indicates the designation of statements for which there is agreement by at least one professional and a citizen. The table also shows the percentage agreement with citizen panel members by professionals employed in government (P₁) and professionals employed outside of government service (P₂).

These percentages reflect the total agreement obtained for all 28 professionals (14 for implicit judgement and 14 for explicit judgement). The figures are obtained by dividing the total number of implicit or explicit judges in agreement on a statement by 6 and multiplying by 100. Each service area has 2 implicit judgements and 2 explicit judgements in each panel of judges. There are three categories to be judged resulting in a maximum of 6 judgements for each panel of judges.

Statements which are judged as reflecting normalizing (N) subnormalizing (SN) and least normalizing (LN) judgements are indicated in appendix B(iii) - B(ix) by the appropriate designations contained in table 1.
These statements were then used to develop measures of services and measurement criteria for each of the seven categories of services (Appendix C(i) and C(ii) - (viii)). In Appendix C(i), Normalizing service is defined as therapeutic; subnormalizing service is characterized as maintaining; and least normalizing service is judged as custodial or deviant. Normal scores were then assigned as follows: 3, Normalizing Service; 2, Subnormalizing Service; and 1, Least Normalizing Service.

In order to ensure that the measurement instruments were consistent with implicit and explicit judgement of criteria, the scoring criteria as well as the criteria for each of the seven service areas were re-submitted to the respective panel of judges for examination. In other words, all of Appendix C(i) to C(viii) were checked by the appropriate panel of judges for consistency with established judgements of services. Only the first set of judges was used to validate the instrument because of the strike by postal workers during the period of study.

4.2.2 Stage II

A certificate of approval to undertake study was sought and obtained from the University of British Columbia since the study involved human subjects (Appendix A(i)). Permission to obtain retrospective data and possibly to interview staff was also sought and obtained from the Ministry of Human Resources and its offices and agencies within the study area,
and from the volunteer sector in the community (Appendix A(ii) - A(vi); also Chapter 1.0, p.38).

The procedure for obtaining individual needs of former institutional residents involved the following steps: (a) Subjects who met the population criteria specified in subsection 4.1.1 above were obtained from institution records at Woodlands. (b) Individual subject records were then examined for pre-discharge recommendations. This has been in the manner of "Discharge Conference Reports" which had been prepared through the cooperative effort of institution and community care givers. An individual's "discharge conference summary" note states in specific terms, the type of needs and services he or she may require in the community. Some reports venture to identify available and specific community resources. These needs are then identified. Where information contained in records have been insufficient, professional and progress notes were read to complete the information.

Subject characteristics such as age, and sex as well as other information such as level of mental retardation, social age, place of residence, place of discharge, manner of discharge, availability of parent or guardian, age of discharge, and number of years institutionalized were tabulated for each subject.

Subjects were then grouped as A or B according to the period of discharge. For example, Group A, the prenormalization group are subjects who had been discharged during the
five year period between January 1, 1969 and December 31, 1973. Group B, the normalization group are subjects who had been discharged during the five year period between January 1, 1975 and December 31, 1979. Both groups represent the medico-custodial and the social models of service respectively (Chapter 1.0).

4.2.3 Stage III

Individual needs were then traced to community services which had been used to address them (Kessner et al, 1973). Community records were examined, and where necessary, responsible staff were interviewed by the author, only to explain or to complete data. Consistency was maintained in that mostly social workers and social work case-aides were interviewed. This set of professionals were deemed to possess the most complete set of information relating to individuals who have been released from Institutions and are now living in the community. Parents and/or guardians were contacted where necessary in order to complete an information. Proprietors of residential homes, private individuals or volunteer groups were contacted when necessary.

In general, any source which has been identified as having some information relating to the first 12 months of a subject's de-institutionalized community living was contacted, except in instances where the subject had gone out of province, refused to provide information, or has been transferred to Eric Martin Long Term Care Facility in Vancouver Island.
In view of the postal strike during the study period, it was not possible to obtain permission from Eric Martin Facility in Victoria. Also, further investigation necessitated categorizing the facility as an institution. Subjects who have been transferred to other institutions have been excluded from this study.

Individual needs are then linked to specific community services and the latter were scored using the criteria which had been developed from explicit and implicit judgement of normalized services (Brook and Appel, 1973, also, Appendix C). Furthermore needs and services for each individual were tabulated according to whether or not a need has been identified and provided for, identified and not provided for, or additional.

Five criteria, based on the characteristics of normalization identified by Wolfensberger and Calen (1975) were used to evaluate the normalizing content of service characteristics. These are: (a) the nature of the service which have been specifically determined for the particular service. For example whether a residential service is provided in a family home, boarding home or a nursing home or whether a social service is generic for the population at large, (b) the type of service, (c) the name of the service (d) the location of service and (e) the degree to which the service is integrated with generic community services (Appendix C(ii) - (viii)).

The nature and type of service relate to non-deviant structures, the name of the service relates to non-deviant
social interpretation and the location and degree of integration relate to social and functional integration (Wolfensberger & Glen 1975. Also see Chapter 2.0, pp. 90-93). Thus, each individually received service was measured in five different ways to provide a wider measure of the normalizing content. Only services which were actually received either as recommended services or as additional services have been scored for normalizing content.

4.3 Method of Study

226 male and female adults were identified as meeting the criteria specified as population for this study (Subsection 4.1.1). 151 are male and 75 are female. Each category was divided into two groups A and B. Group A comprising of those persons who were discharged under the medical policy of care, January 1, 1969 to December 31, 1973. Group B comprises of those adults who were discharged under the social policy of care, January 1, 1975 to December 31, 1979. Groups A and B represent pre-normalization and normalization groups.

There are 122 male and female adults in Group A, and 104 male and female adults in Group B. Both groups were further subdivided by sex as follows: Group A, male 81, female 41; Group B, male 70, female 34. These figures constitute the entire population of the study as specified under subsection 4.1.1.

The procedure which has been described earlier on in this chapter was then followed (Section 4.2, Table 1) in
conducting the study and in gathering data. The methodology is a comparative one in which Groups A normalization of service scores are compared with those of Group B and determination made regarding the sufficiency of services to identified needs.

Data were unavailable for a total of 19 subjects as follows: Group A male 11 or 13.6%, Group A female 3 or 7.3%, Group B male 3 or 13.6%, Group B female 2 or 5.9%. The number and percentage of the population studied are therefore as follows: Group A male 70 or 86.4%, Group A female 38 or 92.7%, Group B male 67 or 95.7%, Group B female 32 or 94.1%.

Unavailable data were the result of missing files, subjects either in prison or in psychiatric hospitals, grossly insufficient information, or unwillingness to provide data.

4.4 Method of Analysis

The methodology provides for the use of analytical frameworks in explaining or discussing empirical data. These analytical frameworks (Kerr, 1976a, 1976b; Gil, 1976) have been described in Chapter 3.0.

Empirical data have been treated in percentage terms which is considered adequate for the purpose of policy analysis. Results and Analysis are provided in Chapter 5.0.
CHAPTER 5.0
RESULTS AND ANALYSIS

In this Chapter, the results of the study are presented. These results have been analysed in a simplified form to permit the integration of empirical data with analytical frameworks discussed in Chapter 3.0.

Following a discussion of the problem in Chapter 1.0, several sets of research questions were posed (p. 50) from which three sets of hypotheses have been formulated. The following analysis provide empirical results and then proceeds to relate same to analytical frameworks (Chapter 3.0) in discussing relationships to questions and hypotheses.

5.1 Empirical Results

In Table 2, the distribution of several items and their bearings on each of the four subgroups are presented. These items have been presented in percentages of the total population for each subgroup (N) which is the sum of the number of subjects for which data were available (n) and those whose community services data were unavailable (N-n). However, more than 86% of the data for each subgroup population had complete and available data.

On the average, 74% of Group B subjects had relatives as guardians as compared to 63% for Group A subjects. More females, 27.5% Group A, and 17.7% Group B, than males 11.1% Group A and 8.6% Group B had been wards of state. This
MALE | FEMALE
---|---
Group A | Group B | Group A | Group B
N = 81 | N = 70 | N = 41 | N = 34

<table>
<thead>
<tr>
<th>ITEM</th>
<th>MALE No.</th>
<th>%</th>
<th>FEMALE No.</th>
<th>%</th>
<th>MALE No.</th>
<th>%</th>
<th>FEMALE No.</th>
<th>%</th>
</tr>
</thead>
</table>
* Available Data (n) | 70 | 86.4 | 67 | 95.7 | 38 | 92.7 | 32 | 94.1 |
Unavailable Data (N-n) | 11 | 13.6 | 3 | 4.3 | 3 | 7.3 | 2 | 5.9 |
Relative as Guardian | 58 | 71.6 | 54 | 77.1 | 25 | 61.0 | 23 | 67.6 |
Wards of State | 9 | 11.1 | 6 | 8.6 | 11 | 27.5 | 6 | 17.7 |
** Self Discharged | 9 | 11.1 | 6 | 8.6 | 5 | 12.5 | 5 | 14.7 |
*** Other | 5 | 6.2 | 4 | 5.7 | - | - | - | - |
Discharged to own Community | 12 | 14.8 | 10 | 14.2 | 3 | 7.3 | 11 | 32.4 |
Discharged to other Community | 69 | 85.2 | 60 | 85.8 | 38 | 92.7 | 23 | 67.6 |
Average age at Discharge | 26.0 | - | 25.4 | - | 26.5 | - | 25.8 | - |
Average No. Yrs. at Woodlands | 12 | - | 11.4 | - | 11.8 | - | 10.4 | - |
Average Social Age | 10.1 | - | 9.8 | - | 12.5 | - | 11.1 | - |

Table 2 Distribution of Items as percentages of sub-group populations: Male and Female.

* Missing files, subject in prison, psychiatric hospital or unwilling to provide information; or partial information available.

** Records do not indicate any form of guardianship.

*** Institutional record indicate that the individual has been discharged to the community or town from which he or she had been initially admitted.

translates to a total of 32 adults whose records indicate as wards of state. No immediate explanation could be found for the slightly higher percentage of females who have been wards of state in both Groups.

11.4% of Group A subjects and 10.5% of Group B subjects discharged themselves from the institution. This represents 11.1% male and 12.5% female in Group A; and 8.6% male and 14.7% female in Group B. Overall, group difference is not significant. However, there are slightly more "self-discharged" adults in Group B, especially for the female sub group.

6.0% of all males (6.2% Group A, 5.7% Group B) had no indication of guardianship. All of the female subjects in both groups had indication of particular forms of guardianship in their institutional records. Again, no specific reason could be advanced to explain this difference between male and female subjects except to suggest that perhaps families or relatives had been more concerned for their female relatives than for their male relatives. Therefore, it is more likely to indicate this concern by accepting guardianship at the time of admission or subsequently afterwards.

A proportionally higher percentage of subjects in both groups were discharged to communities other than the ones from which they had been initially admitted to the institution. This represents 87.7% of pre-normalization Group A and 79.8% of normalization Group B for all sexes. One may suggest that the difference of 7.9% between the two groups has been the
result of increased awareness by guardians and relatives of the necessity to participate actively in the planning of community placement of their wards. This awareness may have been helped by the activities of the volunteer and advocate groups through continual media presentations and challenges to government policy for mentally retarded persons.

The tabulation of these results according to subgroups (Table 2) provide some interesting findings. Firstly, there is no difference in the percentage of male subjects for each subgroup who had been discharged to communities other than their own. This represents 85.2% of all males in Group A and 85.8% of all males in Group B. However, a proportionally higher percentage is found among female subgroups (Table 2). 92.7% of females in Group A as opposed to 67.6% of females in Group B had been discharged to communities other than the ones from which they had been initially admitted to Woodlands. A proportionally higher percentage of females, 32.4% discharged between January 1, 1975 and December 31, 1979 were returned to their home communities from Woodlands in contrast to 7.3% of females in Group A.

An explanation for this difference may be suggested as an increase in family concern for their retarded female members after the "socialization" of care for the mentally retarded in 1974. The custodial model was being challenged and the "protection" offered by the institution was no longer guaranteed. Therefore, the concern for female relatives which had been indicated earlier, and the supposition that females may not
be as well prepared to meet social challenges in the community may have tilted the balance in favour of female subjects at the time. A second reason may be the result of the activities of the Community Living Board (Chapter 1.0, pp. 40-41) which was established in 1978 to help place institution residents from Woodlands to the community. The latter explanation is not as compelling as the first in that both male and female persons were involved in the activities of the CLB. However, more families may have indicated preference in having their daughters or female relatives closer to home.

The average age at discharge for Group A is 26.3 years (26.0 years for males and 26.5 years for females). The average age at discharge for Group B is 25.6 years (25.4 years for males and 25.8 years for females). Group A subjects were institutionalized for one year longer than Group B subjects (11.9 Group A, 10.9 Group B). The average number of years of institutionalization for male and female subgroups are shown in Table 2. Overall, the differences in average age at discharge and average number of years in Woodlands is not considered significant to an appreciable degree. Similarly, the difference in average social age - 11.3, Group A; 10.5, Group B - is not considered significant. However female subgroups had higher average social ages, 12.5 Group A and 11.1 Group B, than male subgroups, 10.1 Group A and 9.8 Group B.

5.1.1 Needs and Services

A total of 214 individual needs were identified for Group
A subjects (142 male, 72 female). 183 individual needs were identified for Group B (131 male, 52 female) (Table 3). On the average, 78.5% of total identified needs for Group A, and 79.8% for Group B received services in the community. The figures by sex are 80.3% male Group A, 80.9% male Group B, 75% female Group A, 76.9% female Group B. Specifically, 80.5% of identified needs of all male subjects were provided with services. The corresponding figure for females is 75.8%. Slightly less than 20% of identified needs of males and slightly less than 26% of identified needs of females were not provided with community services (Table 3).

Additional services which were provided for needs which had not been identified at the time of discharge were calculated as percentages of total needs for each subgroup (Table 3). This translates into 89.4% of additional services for Male Group A; 106.9% for Male Group B; 80.5% for female Group A; and 103.8% for female Group B. Thus, the total number of additional services for the normalization Group B exceeds the total number of identified needs at the time of discharge. Also, additional number of services provided for the pre-normalization Group A are more than 84% of the number of identified needs at time of discharge or community placement.

These findings are consistent with the hypothesis that past and present services do not adequately address the needs of retarded adults living in the community (Chapter 1.0, p. 51).

These findings may be explained in the following ways:
<table>
<thead>
<tr>
<th>Need/Service Category</th>
<th>MALE</th>
<th></th>
<th>MALE</th>
<th></th>
<th>FEMALE</th>
<th></th>
<th>FEMALE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group A</td>
<td>Group B</td>
<td>Group A</td>
<td>Group B</td>
<td>Group A</td>
<td>Group B</td>
<td>Group A</td>
<td>Group B</td>
</tr>
<tr>
<td>* Total No. of Identified Individual Needs</td>
<td>142</td>
<td>100</td>
<td>131</td>
<td>100</td>
<td>72</td>
<td>100</td>
<td>52</td>
<td>100</td>
</tr>
<tr>
<td>* No. of Identified needs for which services were received.</td>
<td>114</td>
<td>80.3</td>
<td>106</td>
<td>80.9</td>
<td>54</td>
<td>75.0</td>
<td>40</td>
<td>76.9</td>
</tr>
<tr>
<td>* No. of identified needs for which services were not received.</td>
<td>28</td>
<td>19.7</td>
<td>25</td>
<td>19.1</td>
<td>18</td>
<td>25.0</td>
<td>12</td>
<td>23.1</td>
</tr>
<tr>
<td>** No. of additional services (i.e. not identified but which were received).</td>
<td>127</td>
<td>89.4</td>
<td>140</td>
<td>106.9</td>
<td>58</td>
<td>80.5</td>
<td>54</td>
<td>103.8</td>
</tr>
</tbody>
</table>

Table 3: Nos. of Services received and not received as percentages of identified needs/services for each sub group.

* Include residential needs/services.

** Excludes residential needs/services.
(a) It is possible that the determination of individual needs within the institution prior to community placement is not sufficiently related to actual community services and needs. It may be that such determinations are made with existing community services in mind. Also, the composition of institutional discharge conferences may have been dominated by professionals whose experiences have been largely in custodial care and "gate-keeping." Indeed such appears to be the case on further examination of discharge conference records. (b) It is possible that social and bureaucratic mechanisms already in place in the community are not flexible enough to permit adjustment to needs and services. Thus individual care givers or social workers in the community are left to push for additional services within the first year of community placements as the real needs of retarded individuals become apparent. (c) The increase in awareness which has been made possible by advocate groups to the needs of retarded persons as well as the social determination of retardation problems under the policy of normalization may have been responsible for the very high number of additional services which were provided for Group B adults.

5.1.2 Distribution of Subjects in Community

Table 4 shows the distribution of study population to community residential facilities. The numbers have been expressed as percentages of total population,

67.2% of all adults in Group A (66.7% male, 68.3% female)
<table>
<thead>
<tr>
<th>Residential Facility</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group A N = 81</td>
<td>Group B N = 70</td>
</tr>
<tr>
<td>Boarding Home</td>
<td>54 66.7%</td>
<td>38 54.3%</td>
</tr>
<tr>
<td>Family Home</td>
<td>9 11.1%</td>
<td>6 8.6%</td>
</tr>
<tr>
<td>Group Home</td>
<td>- -</td>
<td>3 4.3%</td>
</tr>
<tr>
<td>Extended Care</td>
<td>- -</td>
<td>4 5.7%</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>- -</td>
<td>1 1.4%</td>
</tr>
<tr>
<td>* Own Home/Apartment</td>
<td>9 11.1%</td>
<td>3 4.3%</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>- -</td>
<td>1 1.4%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>- -</td>
<td>1 1.4%</td>
</tr>
<tr>
<td>Foster Home</td>
<td>1 1.4%</td>
<td>- -</td>
</tr>
<tr>
<td>Psychiatric Hospital</td>
<td>- -</td>
<td>2 2.9%</td>
</tr>
<tr>
<td>Prison</td>
<td>1 1.4%</td>
<td>- -</td>
</tr>
<tr>
<td>Out of Province</td>
<td>2 2.5%</td>
<td>1 1.4%</td>
</tr>
<tr>
<td>** Family Care Home</td>
<td>- -</td>
<td>5 7.1%</td>
</tr>
<tr>
<td>*** Treatment &amp; Training Home</td>
<td>- -</td>
<td>3 4.3%</td>
</tr>
<tr>
<td>**** Other</td>
<td>5 6.2%</td>
<td>2 2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>81 100%</td>
<td>70 100%</td>
</tr>
</tbody>
</table>

Table 4 Distribution of Subjects to Residential Facilities as percentage of sub-group populations: Male and Female.

* Assumes responsibility for self or living in own rented apartment or home.

** Live with another family by arrangement with an intermediary agency.

*** Mostly farming and vocational training centres which provide residential living.

**** Unable to determine status, or trace, movement or client's/guardian's refusal to provide information.
were discharged to boarding homes. 49.0% of all adults in Group B (54.3% male, 38.2% female) were discharged to boarding homes. Overall, there were less number and percentage of adults in Group B discharged to boarding homes than was previously discharged to this type of facility from Group A. The difference is 12.4% in favour of males in Group A and 30.1% in favour of females in Group A. However, there were more alternative community residences for Group B than for Group A. Table 4 also shows that during the normalization period, Group B subjects were admitted to boarding homes as well as to Group homes, extended care facilities, long term care facilities, intermediate care homes and nursing homes. Also, intermediary agencies such as the Community Living Board introduced the idea of family care homes as well as Treatment and Training facilities during the normalization period. None of the pre-normalization subjects were admitted to any of these new community homes. The question is therefore whether these additional community facilities are normalizing in the services they provide. This factor will therefore be reflected in the normalization scores for residential services for Group B.

10.6% of pre-normalization subjects (11.1% male, 9.8% female) lived in their own homes or apartment during their first year of community living. The corresponding figure for the normalization group is 6.7% (4.3% male, 11.8% female). However, all admissions to psychiatric hospitals (2.9% male, 2.9% female) were from Group B as well as all discharges to treatment and training homes (4.3% Male Group B). 1.8% of
adults in Group A (1.4 male, 2.4 female) were in prison. Seven persons or 5.7% of Group A and two persons or 1.9% of Group B could not be accounted for.

The significance of table 4 is two fold: (a) A high proportion of all deinstitutionalized subjects were sent to boarding homes in the community. 96.4% of these boarding homes are privately owned and operated for commercial purposes. 92.1% of all boarding homes are being supervised by the Ministry of Health via the Mental Health Centres. Nearly all of the boarding home data and information were obtained from social workers and social work case aids in Mental Health Centres. Therefore, it is reasonable to conclude that there are linkages with the medical model of residential services at least within the framework of boarding homes operation. This factor will later be analysed. (b) New or alternative community residential services were developed during the normalization period. Some of these alternatives have been in place before the change of policy - nursing homes, extended care facilities, - and some of them are new such as family care homes; intermediate care facilities and treatment and training homes. The key question is whether these new community residential facilities are essentially different from boarding homes. (c) Only a small percentage of discharged adults live with their families (11.1% male Group A, 8.6% male Group B; 9.8% female Group A and 11.8% female Group B). These percentages do not reflect real group differences. Thus, it may be said that the trend of deinstitutionalization is not towards returning mentally retarded adults to their family homes.
5.1.3 Distribution of Community Based Services

Table 5 and Table 6 provide further analysis of Table 3. Residential service has been excluded in the analysis in tables 5 and 6 since it is a common factor for all community residents.

Table 5 shows the distribution of absolute numbers of services which although were identified at time of discharge, but nevertheless, were not received by male subjects in Group A and Group B.

Table 6 shows the distribution of services which were not identified at the time of discharge, but were later provided as additional services to meet the community needs of Groups A and B males.

Tables 7 and 8 are the equivalent tables for females in Groups A and B.

The highest number of unmet but identified community services is within vocational services (46.4% male Group A, and 44.0% male Group B). The next areas of unmet services are psychological services for male in Group A (28.6%) and Recreational Services for male in Group B (24.0%). These are followed by Recreation and Educational services for Group A (10.7%); and psychological and educational services for Group B males (12.0%). Overall, there are unmet needs in all categories of services excepting residential and social services for all males.

This situation appears to have been reversed in Table 6.
### Table 5
No. and percentage distribution of services not received, but identified at time of discharge: Male: Group A and Group B

<table>
<thead>
<tr>
<th>*Service/Need</th>
<th>No. of Services</th>
<th>%</th>
<th>No. of Services</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational</td>
<td>13</td>
<td>46.4</td>
<td>11</td>
<td>44.0</td>
</tr>
<tr>
<td>Psychological</td>
<td>8</td>
<td>28.6</td>
<td>3</td>
<td>12.0</td>
</tr>
<tr>
<td>Recreational</td>
<td>3</td>
<td>10.7</td>
<td>6</td>
<td>24.0</td>
</tr>
<tr>
<td>Educational</td>
<td>3</td>
<td>10.7</td>
<td>3</td>
<td>12.0</td>
</tr>
<tr>
<td>Medical</td>
<td>1</td>
<td>3.6</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>Social</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td><strong>100</strong></td>
<td><strong>25</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Excluding residential services.

### Table 6
No. and percentage distribution of services received but not identified at time of discharge: Male: Group A and Group B

<table>
<thead>
<tr>
<th>*Service/Need</th>
<th>No. of Services</th>
<th>%</th>
<th>No. of Services</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>44</td>
<td>34.6</td>
<td>49</td>
<td>35.0</td>
</tr>
<tr>
<td>Medical</td>
<td>32</td>
<td>25.2</td>
<td>45</td>
<td>32.1</td>
</tr>
<tr>
<td>Recreational</td>
<td>27</td>
<td>21.3</td>
<td>45</td>
<td>32.1</td>
</tr>
<tr>
<td>Vocational</td>
<td>18</td>
<td>14.2</td>
<td>27</td>
<td>19.2</td>
</tr>
<tr>
<td>Psychological</td>
<td>6</td>
<td>4.7</td>
<td>4</td>
<td>2.9</td>
</tr>
<tr>
<td>Educational</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127</strong></td>
<td><strong>100</strong></td>
<td><strong>140</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Excluding residential services.
<table>
<thead>
<tr>
<th>*Services/Needs</th>
<th>Group A No. of Services</th>
<th>%</th>
<th>Group B No. of Services</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational</td>
<td>8</td>
<td>44.4</td>
<td>5</td>
<td>41.7</td>
</tr>
<tr>
<td>Psychological</td>
<td>4</td>
<td>22.2</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Recreational</td>
<td>4</td>
<td>22.2</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Educational</td>
<td>1</td>
<td>5.6</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Medical</td>
<td>1</td>
<td>5.6</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Social</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7  No. and percent distribution of services not received but identified at time of discharge. Female: Group A and Group B

*Excluding Residential Services

<table>
<thead>
<tr>
<th>*Services/Needs</th>
<th>Group A No. of Services</th>
<th>%</th>
<th>Group B No. of Services</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>26</td>
<td>44.8</td>
<td>27</td>
<td>50.0</td>
</tr>
<tr>
<td>Medical</td>
<td>10</td>
<td>17.2</td>
<td>12</td>
<td>22.2</td>
</tr>
<tr>
<td>Recreational</td>
<td>14</td>
<td>24.2</td>
<td>8</td>
<td>14.8</td>
</tr>
<tr>
<td>Vocational</td>
<td>1</td>
<td>1.7</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Psychological</td>
<td>7</td>
<td>12.1</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>Educational</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>7.4</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
<td>54</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 8  No. and percent distribution of services received but not identified at time of discharge. Female: Group A and Group B.

*Excluding Residential Services
The largest number of additional services which were provided to meet individual needs but which had not been identified at time of discharge is in the area of Social Services, (34.6% males Group A, and 35.0% males Group B). This is followed by Medical Services (25.2% males Group A, 32.1% males Group B); and Recreational Services (21.3% males Group A, and 19.2% males Group B). More of vocational services were provided additionally for males in Group A than for males in Group B although vocational services straddle the apex of identified but unmet needs of males (Table 5). Also no additional educational service was provided for males in Group A.

With regard to Tables 5 and 6, one may suggest that social service needs in general terms are provided as of routine once an individual has been deinstitutionalized. This need is more real especially in the event that an adult would have to either obtain gainful employment, or be provided for by the state. It is also possible that Social Workers are more apt to involve deinstitutionalized adults in specific social services under the G.A.I.N. legislation (Chapter 1.0, p. 33, note 19). These factors may partially explain why all of the identified social service needs were met and additional social services provided. Social workers perhaps tend to identify more social needs than other professionals.

A surprise finding is the relatively high percentage of medical services (25.2% Group A, 32.1% Group B) which were received as additional services. Specifically, the higher percentage of additional medical needs for the normalization
Group B was not expected. One might have suggested that under the social service model of policy, that the need for medical services would be reduced. The implication may be that there has been increasing dependency on medically related services once subjects have been discharged from the institution where all of their medical needs have been provided as part of overall care. It is equally possible that subjects and their guardians have become more conscious of a variety of medical services once subjects become resident in the community. Some workers report lack of responsibility in doing management and use by retarded adults under free choice.

No additional educational service was provided for males in Group A, but additional 2.9% of educational services were provided for males in Group B.

Overall, except for slight increases in the number of psychological services which were not received by males in Group A, and a slight increase of unmet recreational services for Group B males, the general trend in the provision of services for both groups of males is about the same. This finding essentially substantiates the hypothesis that there is no difference in services for the pre and post normalization groups. A general comment would be that caregivers in the community have perhaps been generally selective in their determination of community needs and services. In general, it would appear that there is lack of coordination in identifying and following up on individual needs and appropriate services with which to meet the needs.
Table 7 and table 8 respectively represent identified but unmet services and additional services for females in the pre-normalization and normalization groups.

The findings for the female subgroups are identical to those of the male subgroups. Vocational services constitute a large proportion of identified but unmet service needs (44.4% Group A, 41.7% Group B). Next are psychological services for Group A (22.2%) and recreational services for Group B (25.0%). As with the male subgroups, all social services which were identified were met.

The figures again, seem to be reversed for additional services which were provided (Table 8). As with the male subgroups, more of additional social services were provided (44.8% Group A, 50.0% Group B). However, unlike with the male subgroups more of recreational services were next provided for female Group A (24.2%), but more of additional medical services were provided for female Group B (22.2%).

There is no ready explanation for the increase in recreational services for females in Group A and in medical services for females in Group B. However, one may observe that voluntary organizations were involved more with recreational services during the earlier periods of their existence, that is in the 1960's. It is possible that more females in Group A were involved in volunteer recreational programs in the late 60's and early 70's before the advent of current system of generic community services.
The increase in additional medical services for both male and female groups poses some concern. It has been expected that there would be a decrease in medical services under the normalized social model of care. This expectation has not been substantiated. Either that more medical needs of retarded adults are being identified outside of the institution, or that some difficult social problems are being referred for medical solution, and or containment. There is a need to look at the pattern of medical services utilization by de-institutionalized retarded adults.

5.1.4 Intellectual Level and Social Age

Table 9 shows the distribution of Levels of Intelligence for Pre-normalization Group A and Normalization Group B. The tabulation reflects recorded intellectual levels at the time of discharge from the Institution.

38.6% of the subjects were assessed as having normal, mild or moderate intelligence, and 61.4% as possessing severe or profound levels of mental retardation (Chapter 2.0, pp. 61-62). Of the first category, 4.8% were assessed as having normal intelligence, that is an intelligence quotient of 70 points or above. An examination of the institutional records of the 10 adults who were judged as being "normal" during discharge from Woodlands indicate a variety of initial individual problems. These problems range from sexual exhibitionism, homosexuality and slow childhood mental development to abandonment at birth. In other words, some of these problems were regarded
### INTELLECTUAL LEVEL: MALE AND FEMALE

<table>
<thead>
<tr>
<th><em>I.Q.</em></th>
<th>Normal &gt;70</th>
<th>Mild 55 - 69</th>
<th>Moderate 36 - 51</th>
<th>Severe 20 - 35</th>
<th>Profound &lt;20</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Pre-Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>4 3.7</td>
<td>16 14.8</td>
<td>24 22.2</td>
<td>35 32.4</td>
<td>29 26.9</td>
<td>108 100</td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>6 6.1</td>
<td>12 12.1</td>
<td>18 18.1</td>
<td>36 36.4</td>
<td>27 27.3</td>
<td>99 100</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10 4.8</td>
<td>28 13.5</td>
<td>42 20.3</td>
<td>71 34.3</td>
<td>56 27.1</td>
<td>207 100</td>
</tr>
</tbody>
</table>

* Intellectual Quotient

Table 9: No. and Percentage distribution of recorded intellectual level for Male and Female Subjects: Group A and Group B.
as deviancy and were consequently categorized under mental retardation, perhaps due to inadequate resource or mechanism for dealing with the problems. It is rather inconceivable in today's world that homosexuality will be classified under mental retardation.

It has been expected that more of retarded adults within the mild and moderate levels of retardation (I.Q. 36-69) would constitute the majority of de-institutionalized adults. This expectation had been based on the conception that less severely retarded adults would more ably cope and adjust in the community, and that available community resources would better fit their needs. However, this expectation has not been substantiated in general terms. 61.4% of the subjects were classified as either severely or profoundly mentally retarded (I.Q. 0-35). This trend is also reflected in the two groups. 59.2% of adults in Group A and 63.6% of adults in Group B have been classified as severely or profoundly mentally retarded. The higher percentage of discharged severely or profoundly retarded adults in the Normalization Group perhaps indicates the fact that more of this category of adults now constitutes a higher percentage of institutional residents (Eni, 1980). It could also mean that under the Normalization policy era, the level of mental retardation has not been a very significant factor in de-institutionalization. However, the more plausible explanation may be that guardians and relatives of institutionalized adults have become more aware of community living alternatives and so have become more involved with the welfare of their kin
as persons rather than as deviants. This orientation may have been helped by public discussions of recent years (Chapter 1.0, pp. 5-6).

The positive relationship between Intelligence Quotient (I.Q.) and problems with community adjustment has been demonstrated (Bell, 1976, Chapter 2.0, p. 95). Higher functioning mentally retarded adults have been found to have problems adjusting in the community.

Table 10 compares the intellectual levels of male subjects in the pre-normalization and normalization Groups. 55.7% of severely and profoundly retarded adults in Group A and 59.7% of similar adults in Group B comprise the majority of discharged subjects. These percentages do not, in general, reflect major differences as the overall trend in the proportion of severely profoundly retarded adult discharges has been maintained.

Table 11 provides similar comparison for females in Group A and Group B. The figures show that, although the same trend has been maintained, the proportion of discharged severely/profoundly mentally retarded females in both groups - as compared to males in Table 10 - is higher (65.9% Group A, 71.9% Group B). The figures appear to indicate that more of severely/profoundly retarded females have been discharged proportionally in the two groups.

In general, the distribution of levels of intelligence in
### INTELLECTUAL LEVEL: MALE

<table>
<thead>
<tr>
<th>I.Q.</th>
<th>Normal &gt; 70</th>
<th>Mild 55 - 69</th>
<th>Moderate 36 - 51</th>
<th>Severe 20 - 35</th>
<th>Profound &lt; 20</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Pre-Normalization A</td>
<td>2</td>
<td>2.9</td>
<td>12</td>
<td>17.1</td>
<td>17</td>
<td>24.3</td>
</tr>
<tr>
<td>Normalization B</td>
<td>4</td>
<td>6.0</td>
<td>9</td>
<td>13.4</td>
<td>14</td>
<td>20.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>4.4</td>
<td>21</td>
<td>15.3</td>
<td>31</td>
<td>22.6</td>
</tr>
</tbody>
</table>

Table 10: No. and percentage distribution of recorded intellectual level: Male, Group A and Group B

### INTELLECTUAL LEVEL: FEMALE

<table>
<thead>
<tr>
<th>I.Q.</th>
<th>Normal &gt; 70</th>
<th>Mild 55 - 69</th>
<th>Moderate 36 - 51</th>
<th>Severe 20 - 35</th>
<th>Profound &lt; 20</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Pre-Normalization A</td>
<td>2</td>
<td>5.3</td>
<td>4</td>
<td>10.5</td>
<td>7</td>
<td>18.4</td>
</tr>
<tr>
<td>Normalization B</td>
<td>2</td>
<td>6.3</td>
<td>3</td>
<td>9.4</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4</td>
<td>5.7</td>
<td>7</td>
<td>10.0</td>
<td>11</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Table 11: No. and percentage distribution of recorded intellectual level: Female, Group A and Group B
both groups or by sex is fairly uniform and consistent. However, more of the very intellectually impaired females, especially from among Group B females appear to have been placed in the community.

Table 12 compares recorded social age levels of pre-normalization and normalization Groups. It has been observed that training in Social Skills correlates positively with community placement (Stacy, Doleys and Malcolm, 1979. See also Chapter 2.0, p. 96). Also, Eyman et al (1979, Chapter 2, p. 96) have found that some principles of normalization are related to the level of social development of retarded persons. Table 12 shows that 69.4% of Group A adults and 70.7% of Group B adults have been recorded as having a social age between 6 and 10 years. 70% of all subjects have a social age between 6 years and 10 years. A relatively small proportion of adults 2.9% are between 0 and 5 years in social age. 27.1% of the subjects have higher social ages between 11 years and 20 years. Therefore a typical de-institutionalized adult from Woodlands could be regarded as someone whose social age and therefore whose adaptive capability is within the comparable age levels of 6 years to 10 years.

Table 13 and Table 14 display social age distribution among male and female subjects respectively. The general trend is similar in that 72.3% of males and 65.7% of females are within the 6 years to 10 years social age levels. A comparatively small proportion of males (2.9%) and females (2.8%) are within the 0-5 years social age level. 24.8% of
### SOCIAL AGE: MALE AND FEMALE

**Table 12:** No. and percentage distribution of recorded social age level for male and female subjects: Group A and Group B.

<table>
<thead>
<tr>
<th>S.A. Group</th>
<th>0-5 yrs.</th>
<th>6-10 yrs.</th>
<th>11-15 yrs.</th>
<th>16-20 yrs.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Pre-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>2 1.9</td>
<td>75 69.4</td>
<td>13 12.0</td>
<td>18 16.7</td>
<td>108 100</td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>4 4.1</td>
<td>70 70.7</td>
<td>12 12.1</td>
<td>13 13.1</td>
<td>99 100</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6 2.9</td>
<td>145 70.0</td>
<td>25 12.1</td>
<td>31 15.0</td>
<td>207 100</td>
</tr>
</tbody>
</table>

### SOCIAL AGE: MALE

**Table 13:** No. and percentage distribution of recorded social age level: Male Group A and Group B.

<table>
<thead>
<tr>
<th>S.A. Group</th>
<th>0-5 yrs.</th>
<th>6-10 yrs.</th>
<th>11-15 yrs.</th>
<th>16-20 yrs.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Pre-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>1 1.4</td>
<td>49 70.2</td>
<td>9 12.8</td>
<td>11 15.6</td>
<td>70 100</td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>3 4.5</td>
<td>50 74.6</td>
<td>6 9.0</td>
<td>8 11.9</td>
<td>67 100</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4 2.9</td>
<td>99 72.3</td>
<td>15 10.9</td>
<td>19 13.9</td>
<td>137 100</td>
</tr>
</tbody>
</table>

### SOCIAL AGE: FEMALE

**Table 14:** No. and percentage distribution of recorded social age: Female Group A and Group B.

<table>
<thead>
<tr>
<th>S.A. Group</th>
<th>0-5 yrs.</th>
<th>6-10 yrs.</th>
<th>11-15 yrs.</th>
<th>16-20 yrs.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>Pre-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>1 2.6</td>
<td>26 68.4</td>
<td>4 10.5</td>
<td>7 18.4</td>
<td>38 100</td>
</tr>
<tr>
<td>Normalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>1 3.1</td>
<td>20 62.5</td>
<td>6 18.8</td>
<td>5 15.6</td>
<td>32 100</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2 2.8</td>
<td>46 65.7</td>
<td>10 14.3</td>
<td>12 17.1</td>
<td>70 100</td>
</tr>
</tbody>
</table>
adult males and 31.4% of adult females are within the 11 years to 20 years age levels.

If it is indeed correct that a typical discharged mentally retarded adult from Woodlands has a social age capability within 6 and 10 years, the question therefore arises as to his or her adaptive capability as an independent member of society in view of social complexities raised in Chapter 1.0 (pp. 77-20). Present day social demands require certain abilities such as in making decisions, informed choice and interpersonal relationships with other members of society. Industrialization, urbanization and technological advances would appear to constitute further problems for a 6 or 10 year old especially if normalized living is expected. On the other hand, there are moral questions with respect to the continued retention of such an individual within the confines of the institution, especially if the person is in no danger to himself or to other members of society.

5.1.5 Normalization Content in Services

Services which had been provided to meet individual needs were scored to determine the extent of normalization in them. The criteria for determining levels of normalization in a service are detailed in appendix C. A service is normalizing or therapeutic if (a) it is applicable to all sections of the community, (b) the process cannot be distinguished from everyday behaviour or expectations of people in general or (c) it cannot be interpreted as unique to the mentally retarded or
to any other group with disability (Nominal Score: 3).

A service is sub-normalizing or maintaining in nature if (a) the service or behaviour may or may not be applicable to all sections of the community. In other words it is difficult to make a clear judgement as to the generic or specific nature of the service. (b) The service or process may or may not be interpreted as unique to mental retardation or to any other group with disability (Nominal Score: 2).

A service is least normalizing or Custodial or Deviant if (a) the service is distinctively controlling or only applicable to mental retardation or to any other disability group, (b) the process can be distinguished from everyday behaviour or expectations of people in general, (c) the service or process is unique to a disability group or to mental retardation (Nominal Score: 3).

Each of the seven services measured have specific criteria for measuring them which has been based on implicit and explicit judgements discussed in Chapters 3.0 and 4.0. Each service has been scored individually. A subject may have more than one need. The maximum number of needs for some subjects is five. The average number of needs is three.

The distribution of all services per score of normalization measure is tabulated in Table 15. 24.6% of all services were normalizing. 29.8% of all services were judged as somewhat between normalizing and deviant. In other words, they were sub-normalizing. 45.6% of all services were judged as
### Score and Level of Normalization

<table>
<thead>
<tr>
<th>Score:</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>Normalizing No. (%)</td>
<td>Sub-Normalizing No. (%)</td>
<td>Least Normalizing No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>Pre-Normalization Group A Male &amp; Female</td>
<td>439 (22.9)</td>
<td>639 (33.4)</td>
<td>837 (43.7)</td>
<td>1,915 (100)</td>
</tr>
<tr>
<td>Normalization Group B Male &amp; Female</td>
<td>497 (26.4)</td>
<td>493 (26.2)</td>
<td>895 (47.4)</td>
<td>1,885 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>936 (24.6)</td>
<td>1,132 (29.8)</td>
<td>1,732 (45.6)</td>
<td>3,800 (100)</td>
</tr>
</tbody>
</table>

Table 15 No. and percentage score, for each measure of normalization content. Group A and Group B: Male and Female.
Least-Normalizing, custodial or deviant. There were more deviant or least normalizing services than there were normalizing or sub-normalizing services.

This pattern is reflected in the distribution of normalization content for each group. About one quarter of all group services were normalizing (Group A 22.9%, Group B 26.4%). Deviant services constitute 43.7% of Group A services and 47.4% of Group B services. These figures show that there were slightly more deviant services provided for the Normalization Group B than for Pre-Normalization Group A. However, the figures also show a slight increase in normalized services for Group B.

Table 16 is a breakdown of normalization scores for males in Group A and Group B. Again, the general trend has been maintained. About one quarter or less of all services for each group was judged normalizing - 22.9% Group A, 25.3% Group B. Nearly half of all services in each group are least normalizing - 42.7% Group A and 48.3% Group B.

In general, there is little perceptible difference in normalization content for the pre-normalization and the Normalization Groups.

Table 17 compares normalization content for female subjects in both groups. Again, the general trend has been maintained. About one quarter of services for female subjects were normalizing - 22.9% Group A, 28.6% Group B. The percentage of deviant services for both female Groups was about the same - 45.4%
### SCORE AND LEVEL OF NORMALIZATION

#### Group A

<table>
<thead>
<tr>
<th>Score:</th>
<th>Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Normalization</td>
<td>3</td>
<td>267 (22.9)</td>
<td>172 (22.9)</td>
</tr>
<tr>
<td>Normalization</td>
<td>2</td>
<td>401 (34.4)</td>
<td>238 (31.7)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>497 (42.7)</td>
<td>340 (45.4)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,165 (100)</td>
<td>750 (100)</td>
</tr>
</tbody>
</table>

#### Group B

<table>
<thead>
<tr>
<th>Score:</th>
<th>Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Normalization</td>
<td>3</td>
<td>317 (25.3)</td>
<td>180 (28.6)</td>
</tr>
<tr>
<td>Normalization</td>
<td>2</td>
<td>332 (26.5)</td>
<td>161 (25.6)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>606 (48.3)</td>
<td>289 (45.8)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,255 (100)</td>
<td>630 (100)</td>
</tr>
</tbody>
</table>

### Table 16
Total number and percentage score for each measure of normalization content. Male Group A and Group B

### SCORE AND LEVEL OF NORMALIZATION

#### Group A

<table>
<thead>
<tr>
<th>Score:</th>
<th>Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Normalization</td>
<td>3</td>
<td>172 (22.9)</td>
<td>180 (28.6)</td>
</tr>
<tr>
<td>Normalization</td>
<td>2</td>
<td>238 (31.7)</td>
<td>161 (25.6)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>340 (45.4)</td>
<td>289 (45.8)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>750 (100)</td>
<td>630 (100)</td>
</tr>
</tbody>
</table>

#### Group B

<table>
<thead>
<tr>
<th>Score:</th>
<th>Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Normalization</td>
<td>3</td>
<td>352 (25.5)</td>
<td>399 (28.9)</td>
</tr>
<tr>
<td>Normalization</td>
<td>2</td>
<td>399 (28.9)</td>
<td>629 (45.6)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>629 (45.6)</td>
<td>629 (45.6)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,380 (100)</td>
<td>1,380 (100)</td>
</tr>
</tbody>
</table>

### Table 17
Total number and percentage score for each measure of normalization content. Female Group A and Group B
Group A, 45.8% Group B.

Table 18 and Table 19 compares the distribution of normalization content of services for males and females in each group. Male and female subjects in Group A had even scores for normalizing services 22.9% male, 22.9% female. The least normalizing services made up 42.7% and 45.4% of male and female services respectively.

However, Group B female subjects had slightly more normalized services (28.6%) than Group B male subjects (25.3%) (Table 19). Also there is a slight drop in the percentage of least-normalizing services for Group B female subjects (45.8%) compared to Group B male subjects (48.3%). This is the first time there has been a drop rather than a slight increase in the percentage of Group B least normalizing scores compared to Group A least normalizing scores.

Overall, there is some consistency in the manner normalization content has been distributed in services used to meet the needs of Group A and Group B. In both the pre-normalization and Normalization Groups, about one quarter of all services were normalized and slightly less than half were deviant. The slight drop in deviant services for Group B female subjects could not be explained. Nevertheless, from all the figures for both Groups, one could conclude that no major difference exists in the content of normalization. A general trend has been maintained in which both the ratio and the content of normalization was constant over the years.
### SCORE AND LEVEL OF NORMALIZATION

<table>
<thead>
<tr>
<th>Score:</th>
<th>3 Normalizing No. (%)</th>
<th>2 Sub-Normalizing No. (%)</th>
<th>1 Least Normalizing No. (%)</th>
<th>Total No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Male</td>
<td>267 (22.9)</td>
<td>401 (34.4)</td>
<td>497 (42.7)</td>
<td>1,165</td>
</tr>
<tr>
<td>A Female</td>
<td>172 (22.9)</td>
<td>238 (31.7)</td>
<td>340 (45.4)</td>
<td>750</td>
</tr>
<tr>
<td>TOTAL</td>
<td>439 (22.9)</td>
<td>639 (33.4)</td>
<td>837 (43.7)</td>
<td>1,915</td>
</tr>
</tbody>
</table>

Table 18 No. and percentage score for each measure of normalization content: Male Group A and Female Group A

### SCORE AND LEVEL OF NORMALIZATION

<table>
<thead>
<tr>
<th>Score:</th>
<th>3 Normalizing No. (%)</th>
<th>2 Sub-Normalizing No. (%)</th>
<th>1 Least Normalizing No. (%)</th>
<th>Total No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Male</td>
<td>317 (25.3)</td>
<td>332 (26.5)</td>
<td>606 (48.3)</td>
<td>1,255 (100)</td>
</tr>
<tr>
<td>B Female</td>
<td>180 (28.6)</td>
<td>161 (25.6)</td>
<td>289 (45.8)</td>
<td>630 (100)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>497 (26.3)</td>
<td>493 (26.2)</td>
<td>895 (47.5)</td>
<td>1,885 (100)</td>
</tr>
</tbody>
</table>

Table 19 No. and percentage score for each measure of normalization content: Male Group B and Female Group B.
irrespective of changes in policy.

Table 20 and Table 21 show the number and percentage of services scored per level of normalization for males and females respectively.

Table 20 shows the following features: (a) There were more normalized residential services for males in Group A (30.0%) than for males in Group B (21.1%). This feature has been unexpected. One would have expected to observe more normalized services under the social policy than under the medico-custodial policy. It would appear that several of the new community residential alternatives which were introduced after 1974 were deviant in themselves (See table 4). Except for Family Care Homes, other residential alternatives such as Long Term Care, extended care homes, nursing care homes and to some extent, Group homes, tended to score very little in measured normalization content using study criteria. (b) Males in Group B used slightly more of medical services (38.2%) than males in Group A (34.8%). (c) All of the psychology services for male Group A (8.0%) and male Group B (7.4%) were scored as deviant services. (c) No educational services were provided for Group A males. Only 5.0% of educational services for Group B males were normalized. (d) Group A males had more deviant social services (36.8%) than Group B males (24.0%). (e) Group B males had more least normalizing vocational services than Group A males.

Except for the above observations, the pattern and
Table 20: No. and percentage of services scored per level of normalization: Male Group A and Group B

<table>
<thead>
<tr>
<th>Group</th>
<th>Normalization Score</th>
<th>RES. No.</th>
<th>RES. %</th>
<th>MED. No.</th>
<th>MED. %</th>
<th>SOC. No.</th>
<th>SOC. %</th>
<th>PSYCH. No.</th>
<th>PSYCH. %</th>
<th>REC. No.</th>
<th>REC. %</th>
<th>VOC. No.</th>
<th>VOC. %</th>
<th>ED. No.</th>
<th>ED. %</th>
<th>TOTAL No.</th>
<th>TOTAL %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Normalization</td>
<td>3</td>
<td>80</td>
<td>30.0</td>
<td>93</td>
<td>34.8</td>
<td>20</td>
<td>7.5</td>
<td>0</td>
<td>0</td>
<td>41</td>
<td>15.4</td>
<td>33</td>
<td>12.3</td>
<td>0</td>
<td>0</td>
<td>267</td>
<td>100</td>
</tr>
<tr>
<td>Group A Male</td>
<td>2</td>
<td>80</td>
<td>20.0</td>
<td>152</td>
<td>38.0</td>
<td>57</td>
<td>14.2</td>
<td>0</td>
<td>0</td>
<td>95</td>
<td>23.7</td>
<td>17</td>
<td>4.1</td>
<td>0</td>
<td>0</td>
<td>401</td>
<td>100</td>
</tr>
<tr>
<td>Normalization</td>
<td>3</td>
<td>67</td>
<td>21.1</td>
<td>121</td>
<td>38.2</td>
<td>27</td>
<td>8.5</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>15.8</td>
<td>36</td>
<td>11.4</td>
<td>16</td>
<td>5.0</td>
<td>317</td>
<td>100</td>
</tr>
<tr>
<td>Group B Male</td>
<td>2</td>
<td>77</td>
<td>23.2</td>
<td>106</td>
<td>31.9</td>
<td>82</td>
<td>24.7</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>9.1</td>
<td>25</td>
<td>7.5</td>
<td>12</td>
<td>3.6</td>
<td>332</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>191</td>
<td>31.5</td>
<td>33</td>
<td>5.5</td>
<td>146</td>
<td>24.0</td>
<td>45</td>
<td>7.4</td>
<td>75</td>
<td>12.4</td>
<td>84</td>
<td>13.9</td>
<td>32</td>
<td>5.3</td>
<td>606</td>
<td>100</td>
</tr>
</tbody>
</table>

Key

3: Normalizing
2: Sub-normalizing
1: Least Normalizing
distribution of normalization content in Groups A and B services appear to be similar. It is remarkable that no deviant medical services were observed for Group A males whereas 5.5% of deviant medical services were scored for Normalization Group B males.

Table 21 compares normalization content of services for females in Group A and Group B. The same general observations for male subjects seem applicable to female subjects. (a) There were more normalized residential services for Group A females (32.0%) than for Group B females (24.4%). (b) Group B females used slightly more normalized medical services (32.8%) than Group A female subjects (29.1%). (c) No educational services were provided for Group A female subjects. (d) Group A females had slightly more deviant social services (33.8%) than Group B female subjects (27.7%). (d) Unlike the men in Group A, Group A females had more deviant vocational services (13.2%) than Group B females (9.0%). (e) All psychology services in both groups were scored at least normalizing (11.5% Group A female, 6.9% Group B female).

In general, the pattern of distribution of normalization content appear similar for the pre-normalization and normalization Groups.

Table 22 and Table 23 display normalization content scores and service characteristics for males in the Pre-normalization Group A and Normalization Group B. The Tables show the normalization scores for the nature, type, name, location and extent of integration as characteristics of each of the seven services.
### SERVICES

<table>
<thead>
<tr>
<th>Criteria</th>
<th>RES.</th>
<th>MED.</th>
<th>SOC.</th>
<th>PSYCH.</th>
<th>REC.</th>
<th>VOC.</th>
<th>ED.</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Normalization Group A Female</td>
<td>3</td>
<td>55</td>
<td>32.0</td>
<td>50</td>
<td>29.1</td>
<td>15</td>
<td>8.7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>33</td>
<td>13.9</td>
<td>76</td>
<td>31.9</td>
<td>40</td>
<td>16.8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>102</td>
<td>30.0</td>
<td>14</td>
<td>4.1</td>
<td>115</td>
<td>33.8</td>
<td>25</td>
</tr>
<tr>
<td>Normalization Group B Female</td>
<td>3</td>
<td>44</td>
<td>24.4</td>
<td>59</td>
<td>32.8</td>
<td>18</td>
<td>10.0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>27</td>
<td>16.8</td>
<td>49</td>
<td>30.4</td>
<td>37</td>
<td>23.0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>89</td>
<td>30.8</td>
<td>12</td>
<td>4.2</td>
<td>80</td>
<td>27.7</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 21: No. and percentage of services scored per level of normalization: Female Group A and Group B

**Key**

3: Normalizing  
2: Sub-normalizing  
1: Least normalizing
### SERVICE CHARACTERISTIC: MALE RESIDENTIAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>PRE-NORMALIZATION: GROUP A</th>
<th>NORMALIZATION: GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>16</td>
<td>22.9</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>53</td>
<td>75.7</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100</td>
<td>70</td>
</tr>
</tbody>
</table>

### SERVICE CHARACTERISTIC: MALE MEDICAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>PRE-NORMALIZATION: GROUP A</th>
<th>NORMALIZATION: GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>13</td>
<td>26.5</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>36</td>
<td>73.5</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>100</td>
<td>49</td>
</tr>
</tbody>
</table>

Key: Nu: Nature of Service  
Ty: Type of Service  
Na: Name of Service  
Lo: Location of Service  
In: Level of Integration

Table 22: No. and percentage distribution of service characteristic scores per level of normalization: Male Group A and Group B (Residential and Medical Services)
## SERVICE CHARACTERISTIC: MALE SOCIAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria</th>
<th>Pre-normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>Nu %</td>
<td>Ty %</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>6</td>
<td>11.5</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>42</td>
<td>80.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

### Normalization Levels
- Normalizing
- Sub-normalizing
- Least Normalizing

**Key:**
- Nu: Nature of Service
- Ty: Type of Service
- Na: Name of Service
- Lo: Location of Service
- In: Level of Integration

## SERVICE CHARACTERISTIC: MALE PSYCHOLOGICAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria</th>
<th>Pre-normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>Nu %</td>
<td>Ty %</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>100</td>
</tr>
</tbody>
</table>

### Normalization Levels
- Normalizing
- Sub-normalizing
- Least Normalizing

**Key:**
- Nu: Nature of Service
- Ty: Type of Service
- Na: Name of Service
- Lo: Location of Service
- In: Level of Integration

**Table 22:**
No. and percentage distribution of service characteristic scores per level of normalization: Male Group A and Group B (Social and Psychological Services)
## SERVICE CHARACTERISTIC: MALE RECREATIONAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria</th>
<th>Score</th>
<th>Pre-Normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nu</td>
<td>Ty</td>
</tr>
<tr>
<td>Normalizing</td>
<td></td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td></td>
<td></td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>35</td>
<td>100</td>
</tr>
</tbody>
</table>

## SERVICE CHARACTERISTIC: MALE VOCATIONAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria</th>
<th>Score</th>
<th>Pre-Normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nu</td>
<td>Ty</td>
</tr>
<tr>
<td>Normalizing</td>
<td></td>
<td></td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td></td>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td></td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>19</td>
<td>100</td>
</tr>
</tbody>
</table>

**Key:**
- **Nu:** Nature of Service
- **Ty:** Type of Service
- **Na:** Name of Service
- **Lo:** Location of Service
- **In:** Level of Integration

**Table 23:** No. and percentage distribution of service characteristic scores per level of normalization: Male Group A and Group B (Recreational and Vocational)
### Service Characteristic: Male Educational Normalization Levels

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>Pre-Normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Key:**
- **Nu:** Nature of Service
- **Ty:** Type of Service
- **Na:** Name of Service
- **Lo:** Location of Service
- **In:** Level of Integration

**Table 23:** No. and percentage distribution of service characteristic scores per level of normalization: Male Group A and Group B (Educational)
The purpose was to locate which aspect of a service had been normalizing or deviant.

A high percentage of the nature, and type of residential services in Group A (75.7%, 68.6%) and Group B (74.7% and 68.7%) are deviant. 70.0% Group A and 68.7% Group B residences had names which could neither be interpreted as normalizing nor as deviantizing. Half of Group A (50.0%) and Group B (50.7%) residential facilities are located in areas which are isolated from normal residential areas. Many of the subjects were found in Boarding homes which have been located in farming countryside away from the original place of initial admission to Woodlands. Many of these privately owned residential facilities had been in operation before the introduction of normalization policy but have continued to receive residents from Woodlands. 70.0% of male residential facilities in Group A and 74.6% of similar facilities in Group B males were exclusively for handicapped groups or for mental retardation. The common feature was that several of the Boarding homes also had mentally ill persons. There was no integration with non-handicapped members of the communities.

Less than one quarter of the five residential characteristics were normalized for males in both Groups.

The nature (Group A 26.5%, Group B 42.3%), Type (Group A 20.4%, Group B 28.9%), Location (Group A 24.5%, Group B 38.5%) and Integration (Group A 24.5%, Group B 38.5%) characteristics of Medical Services for Group B males were more normalized
than for Group A males. However, there were no deviant community services for Group A males. The latter observation may be due to new forms of residential alternatives such as extended care homes and which were essentially medical in orientation.

Medical services for both groups were largely provided in private physicians' offices although more of these were found with Group A males (Group A 93.9%, Group B 84.6%).

The characteristics of social services for males in both Groups, except for location characteristics, were essentially deviant or least normalizing - Nature (Group A 80.8%, Group B 62.7%); Type (Group A 80.8%, Group B 68.6%); Name (Group A 92.3%, Group B 75.6%); Integration (Group A 86.5%, Group B 76.5%). However, a higher percentage of Group A male social services were least normalizing than those of Group B. In both Groups, social services were often located in places which largely scored as sub-normalizing (Group A 80.8%, Group B 86.3%). Social workers from the Ministry of Health, Mental Health division handle most of the services for boarding homes outside of the City of Vancouver, North and West Vancouver. Except for slight increases in the percentage of normalized service characteristics of Nature (13.8%) and Type (15.7%) of Group B male social services, all other characteristics for both Groups were below 8% normalization.

Psychological services were deviant for males in both groups in all service characteristics. There were no normalized
psychological services during both periods under study. This may be due to few number of private psychological services in existence which are oriented towards behaviour modification and mental retardation. It appeared that there was continued dependence for such services on the Institution. Psychology services which were organized by the volunteer sector had been targeted exclusively to the mentally retarded, hence the low normalization scores. The criteria did not measure outcome, but simple characteristics of nature, type, name, location and degree of integration with non-retarded persons.

Table 23 shows the number and percentage distribution of normalization scores per service characteristic for recreational, vocational and educational services.

The nature (88.6%), location (94.3%) and integration (82.9%) of recreational services for males in Group A straddle the boundary between normalized and deviant services. On the other hand, the nature (58.1%) type (51.6%) and integration (83.9%) of recreational services for male Group B services were essentially deviant or least normalizing. However, Group B male recreational services had higher percentage of normalized characteristics of nature (Group A 5.7%, Group B 25.8%), type (Group A 5.7%, Group B 25.8%), location (Group A 5.7%, Group B 41.9%) and integration (Group A 5.7%, Group B 12.9%). From these percentage figures one may infer that the Normalization Group B male subjects had higher numbers of normalized service characteristics than the pre-normalization Group A male subjects.
This finding has been expected in view of the prevailing philosophy of normalized treatment for retarded persons.

The characteristics of vocational services for males in both groups were essentially least normalizing: Nature, (Group A 47.4%, Group B 62.1%), Type (Group A 52.6%, Group B 55.2%), Name (Group A 47.4%, Group B 79.3%) and degree of integration (Group A 63.2%, Group B 79.3%). The locations of vocational services for Group B (55.2%) were slightly more normalized than those of Group A (47.4%). Otherwise all other vocational service characteristics of Group A males had higher normalized percentage scores: Nature (Group A 31.6%, Group B 13.8%); Type (Group A 31.6%, Group B 27.6%), Name (Group A 36.8%, Group B 13.8%) and Integration (Group A 26.3%, Group B 13.8%).

This has been an unexpected finding. There is no ready explanation except to comment that further study may be required in order to find out why pre-normalization vocational services had been more normalized.

Table 23 also shows that Group A subjects did not receive educational service, at least, services that could be detected and measured with the methodology used in this study.

Except for normalized characteristics of nature (66.7%) and location (66.7%) other educational service characteristics were subnormalizing or deviant. Educational services were largely located in community colleges or regular community school buildings. Otherwise, these services were neither
integrated (91.7%) nor given generic names (91.7%). Half of them were decidedly deviant or least normalizing in type.

Table 24 and Table 25 compares scores of service characteristics and levels of normalization for female subjects in Group A and Group B.

Female residential services were essentially deviant in the characteristics of nature (Group A 65.2%, Group B 65.6%), Type (Group A 68.5%, Group B 68.7%), Location (Group A 44.7%, Group B 46.7%) and Integration (Group A 65.8%, Group B 68.7%). Less than 35% of Group A and Group B female residential services were normalized. Overall, the pattern of service characteristic scores and normalization content were similar for both groups.

A slightly higher percentage of female residential services than male residential services for all groups were normalized.

All the service characteristics of Group B female medical services, except in name, were more normalized than those of Group B female subjects: Name (Group A 25.0%, Group B 41.7%), Type (Group A 17.9%, Group B 29.2%), Location (Group A 21.4%, Group B 45.8%) and Integration (Group A 25.0%, Group B 45.8%).

Although the name characteristic of medical services was highly normalized (Group A 89.3%, Group B 83.4%) nevertheless, other medical service characteristics were less than 46% normalized.

Social service characteristics for both female groups,
SERVICE CHARACTERISTIC: FEMALE RESIDENTIAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>PRE-NORMALIZATION: GROUP A</th>
<th>NORMALIZATION: GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>11</td>
<td>28.9</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>2</td>
<td>5.3</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>25</td>
<td>65.6</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>100</td>
<td>38</td>
</tr>
</tbody>
</table>

SERVICE CHARACTERISTIC: FEMALE MEDICAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>PRE-NORMALIZATION: GROUP A</th>
<th>NORMALIZATION: GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>7</td>
<td>25.0</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>20</td>
<td>71.5</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>1</td>
<td>3.5</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100</td>
<td>28</td>
</tr>
</tbody>
</table>

Key: Nu: Nature of Service  Table 24: No. and percentage distribution of service characteristic scores per level of normalization Female Group A and Group B (Residential and Medical Services)
### SERVICE CHARACTERISTIC: FEMALE SOCIAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>Pre-Normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>8.8</td>
<td>3</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>14.7</td>
<td>4</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>76.5</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>34</td>
<td>100</td>
</tr>
</tbody>
</table>

### SERVICE CHARACTERISTIC: FEMALE PSYCHOLOGICAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>Pre-Normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu</td>
<td>Ty</td>
<td>Na</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>100</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5</td>
<td>100</td>
</tr>
</tbody>
</table>

**Key:** Nu: Nature of Service  
Ty: Type of Service  
Na: Name of Service  
Lo: Location of Service  
In: Level of Integration  

**Table 24:** No. and percentage distribution of service characteristic scores per level of normalization Female Group A and Group B (Social and Psychological Services)
much like those of male groups, were essentially least normalizing.

76.5% of the nature of Group A social services and 63.0% of those of Group B were scored as deviant. This trend was also reflected in the scores for type of services (Group A 79.4%, Group B 74.1%), the name of the service (Group A 88.3%, Group B 70.4%) and the degree of integration with generic community services (Group A 82.4%, Group B 81.5%).

These findings are consistent with the kind of statutory arrangement which has been in place for handicapped persons in British Columbia. Under the system, more than 70% of male and female residents of assorted community based boarding homes, extended care homes, nursing homes and long term care homes received only comforts allowances. The bulk of their social services monetary entitlements were largely administered from the administration of these homes, or residences. The Guaranteed Available Income for Need Act (Chapter 1.0, p. 33) under which the Handicapped persons Income Assistance benefits are managed is an exclusive social legislation for disabled persons. This explains why less than 19% of social services for females in both groups were normalized (Group A, less than 9%, Group B less than 19%).

However, table 24 shows that a higher percentage of Group B female social services were normalized compared to Group A female subjects (Group A Nature 8.8%, Type 8.8%, Name 8.8%, Location 8.8%, Integration 8.8%. Group B, Nature 14.8%, Type
18.5%, Name 11.1%, Location 11.1% and Integration 11.1%).

Social services for both Groups were located in offices which were scored as subnormalizing (Group A 79.4%, Group B 81.5%). This may be due to the fact that both the Ministry of Human Resources and the Ministry of Health shares responsibility for community boarding homes, especially outside of the cities of Vancouver, North Vancouver and West Vancouver.

Psychology services (Table 24) were scored as deviant or least normalizing services for both female groups. The reasons for this finding have been suggested as relating to scarcity of independent and private psychological services and continued dependence for such services on Woodlands or on community mental health centres.

Table 25 shows that considerable ambiguity was experienced in involving mentally retarded female subjects in recreational activities. While recreational service characteristics scores for Group A female subjects were largely scored as subnormalizing (Nature 83.3%, Location 86.7% and Integration 80.0%) the scores for Group B female subjects were more diffused across the three levels of normalization.

One explanation perhaps relates to general philosophical orientation towards involvement of retarded persons in a variety of recreational activities and difficulty in defining the extent of the activities without overly being controlling. Another explanation perhaps relates to increased active participation of parents and relatives in the affairs of their
## SERVICE CHARACTERISTIC: FEMALE RECREATIONAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>PRE-NORMALIZATION: GROUP A</th>
<th>NORMALIZATION: GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu. % Ty. % Na. % Lo. % In. %</td>
<td>Nu. % Ty. % Na. % Lo. % In. %</td>
<td>Nu. % Ty. % Na. % Lo. % In. %</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3  2  6.7  3  10.0  24  80.0  3  10.0  2  6.7  6  28.6  5  23.8  12  57.2  10  47.6  3  14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2  25  83.3  0  0.0  2  6.7  26  86.7  24  80.0  4  19.0  6  28.6  4  19.0  9  42.9  4  19.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1  3  10.0  27  90.0  4  13.3  1  3.3  4  13.3  11  52.4  10  47.6  5  23.8  2  9.5  14  66.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>30 100</td>
<td>30 100</td>
<td>30 100</td>
</tr>
</tbody>
</table>

## SERVICE CHARACTERISTIC: FEMALE VOCATIONAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>PRE-NORMALIZATION: GROUP A</th>
<th>NORMALIZATION: GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nu. % Ty. % Na. % Lo. % In. %</td>
<td>Nu. % Ty. % Na. % Lo. % In. %</td>
<td>Nu. % Ty. % Na. % Lo. % In. %</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3  5  33.3  4  26.7  5  33.3  2  13.3  2  13.3  2  22.2  2  22.2  2  22.2  3  33.3  2  22.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-normalizing</td>
<td>2  3  20.0  2  13.3  2  13.3  4  26.7  1  6.7  3  33.3  1  11.1  2  22.2  1  11.1  1  11.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1  7  46.7  9  60.0  8  53.4  9  60.0  12  80.0  4  44.4  6  66.7  5  55.6  5  55.6  6  66.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15 100</td>
<td>15 100</td>
<td>15 100</td>
</tr>
</tbody>
</table>

**Key:** Nu: Nature of Service  Ty: Type of Service  Na: Name of Service  Lo: Location of Service  In: Level of Integration

**Table 25:** No. and percentage distribution of service characteristic scores per level of normalization: Female Group A and Group B (Recreational and Vocational)
### SERVICE CHARACTERISTIC: FEMALE EDUCATIONAL

<table>
<thead>
<tr>
<th>Normalization Levels</th>
<th>Criteria Score</th>
<th>Pre-Normalization: Group A</th>
<th>Normalization: Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Nu</td>
<td>Ty</td>
</tr>
<tr>
<td>Normalizing</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Subnormalizing</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Least Normalizing</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Key:**
- **Nu:** Nature of Service
- **Ty:** Type of Service
- **Na:** Name of Service
- **Lo:** Location of Service
- **In:** Level of Integration

Table 25: No. and percentage distribution of service characteristic scores per level of normalization: Female Group A and Group B (Educational)
retarded members after normalization policy was effected in 1975.

47.6% of Group B female recreational services were located in generic community surroundings compared to 10.0% of Group A female recreational services. In general, the nature (28.6%), Type (23.8%) and Integration (14.3%) characteristics of Group B female recreational services were slightly more normalized than those of Group A female subjects. These percentages are hardly high enough to justify a finding of great increases in the normalizing content of Group B female recreational services, since the equivalent scores for Group A range from 6.7% to 10.0%. Although the name characteristic of female recreational services scored high (80.0% Group A, 57.2% Group B) nevertheless, there were less integration of services with non-retarded adults in Group B (66.7%) than in Group A (13.3%). The trend appeared to be one in which a normalized name was given to a recreational Group B service and all other service characteristics were treated in deviant ways.

The observed differences in the two groups were not unexpected. 90% deviancy in the type of Group A recreational activities had been reduced to 47.6% for Group B female subjects. The concentration of Group A scores at the sub-normalizing levels of normalization had become diffused for all three score levels in Group B subjects. However, an important point has been that the higher percentages of least normalizing recreational service characteristics is concentrated in Group B services.
Vocational services for females in Groups A and B were least normalizing in nature (Group A 46.7%, Group B 44.4%), Type (Group A 60.0%, Group B 66.7%), Name (Group A 53.4%, Group B 55.6%), Location (Group A 60.0%, Group B 55.6%), and Integration (Group A 80.0%, Group B 66.7%).

From these percentages, one could make the observation that overall, vocational services for females, as for males were essentially deviant in the five scored characteristics. Except for the location of vocational service (Group A 13.3%, Group B 33.3%) the percentage of normalized characteristics of nature, type and name decreased from Group A percentages. Nevertheless, less than 35% of Group A Vocational service characteristics, and less than 25% of Group B vocational service characteristics were normalized.

These findings were not unexpected in view of difficulties with obtaining on the job vocational training for mentally retarded adults. Also, the fact that most of the available vocational services were exclusively for mental retardation or other handicapped groups and graduates rarely advance to regular type services.

Educational service was not provided for Group A female subjects (Table 25). 66.7% of the nature and location of educational services for Group B female subjects were normalized. 77.8% of the services were subnormalizing in type, and 77.8% were deviant in name. 88.9% of all educational services for Group B female subjects were not integrated with educational
services for non-mentally retarded adults.

These percentages are consistent with those of male Group B subjects. In general, there was ambivalence with respect to how much normalization was needed in educational services.

5.2 Summary of Empirical Results

The major findings from the data presented above are as follows:

(a) 74% of normalization Group B subjects had their relatives as guardians compared to 63% of pre-normalization Group A subjects. The reason for this difference has been suggested as the increased interest of parents and relatives in the welfare of their retarded members. This increase has been suggested as resulting from the social definition of mental retardation which the volunteer sector has been able to project through public media since 1975.

However, more females had been wards of state in both groups. There is no ready explanation for this finding.

(b) There is no difference in the percentage of self discharged adults in both Groups (Group A 11.4%, Group B 10.5%). It had been expected that a higher percentage of Group B subjects would discharge themselves from Woodlands following the introduction of the social system of service as policy direction. However, a slightly higher percentage of Group B female subjects were recorded as self-discharged.
(c) Significantly high percentages of adults in both groups were discharged to communities other than the one which had been recorded as their home communities or at least as admission communities (Group A 87.7%, Group B 79.8%). Therefore, irrespective of policy change, a significant percentage of retarded adults from Woodlands were discharged to several other communities other than their own. One explanation could be that there are inadequate community resources in their own communities with which to address their needs. Therefore, they were simply slotted to available community residences willing to accept them. Another explanation could be that their guardians and relatives did not wish their return to home communities. The latter explanation is probable in view of the fact that nearly all the female subjects in both groups had guardianship. Yet, many of the female subjects were discharged to other than their home communities. Nevertheless, a more likely explanation could be that both factors of inadequacy of local resources and rejection were responsible for this finding.

(d) There was no difference in either the average age at discharge or the length of institutionalization in years for both groups. However female subjects in both groups had higher average social ages than males, but overall, the slight percentage difference between both groups - male and female combined - is not considered significant (11.3% Group A, 10.5% Group B). On the basis of these percentage
figures, one may not attribute any group differences in services to either average age at discharge or length of institutionalization or social age.

(e) On the average 78.5% of Group A needs and 79.8% of Group B needs were identified and provided with services in the community. Also more than 85.0% of all community based services which were made available to both groups were additional services. With respect to Group B, the percentage of additional services exceeded that of identified needs/services.

This finding substantiates the hypothesis that community services were inadequate for meeting the needs of both groups.

(f) The majority of all subjects in both groups were discharged to boarding homes (Over 65% Group A and over 50% Group B). However, there were new community residential alternatives for Group B subjects which accounted for some reduction in the percentage of boarding home residents. Subsequent normalization data indicated that these alternative residential homes were mostly least normalizing. 94% of the boarding homes were privately operated for commercial purposes.

(g) The highest percentage of unmet needs/services was in the area of vocational services (over 40% for males and females in each group). All identified social service needs were met. However, over 40% of all additional services for
both groups and sexes was in the area of social needs/services. Next in percentage of additional services was in the area of medical needs (Tables 5, 6, 7, 8). It has been suggested that perhaps, more social needs/problems were identified after discharge of subjects from Woodlands. However, the high percentage of additional medical services was not expected.

(h) Over 60% of all subjects were classified as severely or profoundly retarded in both groups. Also the majority of subjects were within the social age of 6 to 10 years for both groups. Thus, a typical de-institutionalized adult from Woodlands would be an adult who would likely possess an intellectual level in the severe/profound retardation range and whose social age was in the area of 6 to 10 years. However, 38.6% of all subjects were either of normal intelligence, or of mild to moderate intellectual levels. No major differences were observed in the two groups.

(i) On the average, all community based services were found to be deviant or least normalizing for both groups and sexes (Group A 43.7%, Group B 47.4%). Only 22.9% of Group A services and 26.4% of Group B services were scored as normalizing. The remainder of the services straddled the boundary between normalizing and deviantizing. This general pattern was maintained for both groups and sexes. Specifically, all psychological services were least normalizing. There were no educational services for Group A male and female subjects. The extent of
normalization varied from one service to the other. For example while medical services were more normalizing than social services. Further examination revealed an imbalance in the content of normalization for various service characteristics. For example, recreational services were highly normalized in the characteristic of name, but highly deviant in integration with non-retarded members of the community. This pattern was fairly consistent but varied only in particular service characteristics such as nature, type or location.

5.3 Policy Analysis

The empirical data which has been presented above have not been subjected to minute or detailed analysis, but are intended to provide some insight to the process of policy development in the area of mental retardation in Greater Vancouver Regions. The methodology used in gathering empirical data did not call for wider generalizations in view of the subjective nature of implicit and explicit judgement of normalization criteria. Therefore the empirical data have been presented in tabular and percentage forms to enable visual comparisons to be made.

Having served this purpose, it has become necessary to integrate the information into a framework for policy analysis.

In Chapter 3.0, the conceptual framework for policy analysis is described. Kerr (1976a) provides four conditions which may be used in the analysis of educational policy (Chapter 3.0, pp. 106-107).
Condition 1. Some authorizing agent (Aa) obligates itself to direct some implementing agent (Ai) to act in accord with some specified conditional imperative (I).

With respect to the policy of Normalization of Services for mentally retarded persons in British Columbia, the authorizing agent (Aa) would be the Government of British Columbia via the Ministry of Human Resources. The form of authorization for this particular social policy can be found in the Annual Reports of the Ministry, and in subsequent policy directories designed to effect the policy of normalization.

The transfer of responsibility for mental retardation from Ministry of Health to Ministry of Human Resources was achieved by way of amendment of the Mental Health Act. There was no subsequent legislation or statute which legitimizes or legalizes normalization as policy as has been done in the Scandinavian Countries (Chapter 2.0, p. 34). Therefore, only broad policy statements in the 1975 Annual report of the Ministry of Human Resources gave indications of the adoption of normalization as a principle. In the legal sense therefore, normalization is a principle and not a policy (Divorkin, 1977, also see Chapter 3.0, p. 104-105). Kerr (1977a) takes the view that when a decision regarding what is to be done is yet to be made, it would seem more correct to say that a principle has been adopted for which a policy might be decided.
The Annual Report of the Ministry of Human Resources merely stated the goals and guiding principles of the Ministry:

- to provide the opportunity for every mentally retarded person to achieve his or her maximum potential.
- opportunity to live with own family or in his or her community and to participate fully in community life.
- opportunity to engage in meaningful occupation.
- a right to economic opportunity.

The above statements do not constitute specific authorization for the implementation of normalization "policy." There are no identifiable implementing agents (Ai) and no clearly defined authorizing Agent (Aa). Moreover, no specified conditional imperatives (I) can be identified. Thus, the initial attempt by the Ministry of Human Resources to "normalize the lives of mentally retarded persons in British Columbia" does not meet Condition 1 of Kerr's policy analysis.

From empirical data, it has been demonstrated that community services for mental retardation has been largely uncoordinated. Therefore there has been high percentages of unmet service needs and a paradox situation in which additional community services were identified in areas where these services had not been identified as necessary. De-institutionalized adults could not be returned to their home communities and the identified needs at time of discharge came to be at variance with actual needs in the community. The consequence has been for professional caregivers to design whatever system of

service delivery that suits their purposes.

Gil (1976) observes that a consequence of poor linkage between policy requirements and empirical data is the lack of correspondence between policy specifications and community requirements, or between value positions. The latter is exemplified by the periodic media dialogue between the volunteer sector and officials of the Ministry of Human Resources. Although both sides in the dialogue agree in principle regarding "normalization," yet, the lack of specifications in policy for implementation work to the disadvantage of mentally retarded persons.

Condition 2 states that the conditional imperative (I) must be of the form to do something which counts as some specified X-ing, without exception, specified conditions (C) occur.

This condition provides a basis for testing a policy requirement. In 1974, the situation was such that residents of institutions such as Woodlands were asked to discharge themselves if they wished at the age of 19. If Kerr's second condition were to hold, there would have been specific service reaction in place. In other words, as the X-ing, that is the discharges occurred, the policy would have specified how de-institutionalized adults would be provided with immediate services and/or opportunities with which to meet the goals of the Ministry. Although, the idea of normalization did not radically depopulate Woodlands, yet, empirical data has shown that there were no major changes in the direction of service delivery. The pre-normalization group did not differ from
the normalization group regarding the use of privately operated, commercial boarding homes. Moreover, the Ministry of Health, via the Mental Health Services Division retained the duty of supervising commercial boarding homes just as before the introduction of normalization "policy." Exceptions were made in certain jurisdictions such as in the City of Vancouver, contrary to the specifications of Condition 2. Empirical data has demonstrated the random application of levels of normalization to the characteristics of services.

The subsequent provision of broad administrative guidelines such as the 1980 Inventory of Services\(^2\) to guide the licencing and operation of residential services, was an attempt to coordinate community services. In time, it will become apparent whether these measures are successful without a baseline of legitimation, authorization and specification.

Condition 3 states that the authorizing agent (Aa) undertakes the obligation (Condition 1) for the purpose of effecting some specified state of affairs (S) and to do so without violating any restrictive rules (R) by which (Aa) would claim to abide.

Under Condition 3, the Government of British Columbia, through the Ministry of Human Resources obligates itself or

---

commits itself to the realization of the normalization of mental retardation services.

Kerr (1977a) makes the point that the authorizing agent (Aa) should observe all the rules and standards it has set for the implementing agent (Ai) while effecting some specified state of affairs (S).

The present study does not address the question of the normalization of government-provided retardation services. Community Services which have been scored for normalization content have been largely administered by the volunteer sector, private individuals and jointly by the government and the volunteer sector. Nevertheless, it may be assumed that Kerr's third condition is not applicable in this study.

Condition 4 states that the authorizing agent's obligation can be revised and yet not be violated both if the authorizing agent announces his revision of the conditional imperative from I to I to those persons who can bring about conditions C to C, and if the authorizing agent gives consideration due the views of the relevant public as defined by the political and moral contexts of the initial policy decision and its revision.

Condition 4 raises three important questions: The first relates to the revision of policy. The second relates to politics and the views of relevant public. The third relates to moral issues.
With respect to the policy revision, there has been no indication that the authorizing agent, that is the Government of British Columbia, has attempted to visibly revise the stated objectives of normalization. If indeed, there has been some overt revision of objectives, it has not been visible in the process of delivery of services. Empirical data indicate that, in fact, the content of normalization for both the pre-normalization group and the normalization group are essentially similar up to 1979. The important observation has been that a continuous linkage has been maintained, at least structurally, with the medical model of care. This fact, negates the notion that a revision of policy has indeed occurred even though a policy transition has been stated.

The second implication of the fourth condition relates to public and political questions. The issue seems to hinge on (a) public attitude as a factor in political decisions and (b) the availability of resources with which to implement normalization policy. This study does not address questions of public attitude nor the distribution of resources. However, it should be noted that public interest and attitude are necessary intervening factors in political decisions in the free world. While the public is sympathetic to issues of handicap in general, there is no evidence that concern for the plight of retarded persons in the community has been sufficient to involve massive commitment of resources. Rather, it would appear that public attitude towards retarded persons in Greater Vancouver Regions has been only to the extent of media
pressure which has largely been supported by advocate groups. The decision to act in one way or another is ultimately a political decision. Normalization "policy" will be legitimized from principle to policy if there is sufficient public interest in favour of legitimation.

The moral aspect of Condition 4 is an individual one, and may be related to attitude and orientation. The basis of normalization principle is essentially moral as well as philosophical. Gil (1976) reminds us of the delicate interface between policy and values and the correspondence between consequences of policy and general requirements of society.

The point has been made earlier regarding the continued institutionalization of mentally retarded adults on the basis of inability to adjust to the demands of contemporary society. From the empirical data, it has been shown that the majority of subjects had social age in the range of 6 years to 10 years. Should such an individual be subjected to the complexities of modern society without some measure of safeguard for his or her personal safety and survival? Alternatively, should the individual be perpetually institutionalized or treated deviantly because of his inability to meet social expectations? When these questions are cross matched with human rights, moral questions are raised. It is therefore not surprising that in the process certain strategies have been developed by segments of the society. As noted in Chapter 1.0, it may be to the interest of professional caregivers to maintain custodial or deviant services. Therefore, they opt to act to protect their
belief in the incurability of mental retardation thus protecting their employment. On the other hand, advocates, whose major experience has been with a mentally retarded relative, would like to equate all forms of retardation to their basic experience, irrespective of other problems.

In conclusion, the results of this study support the hypothesis that there is no difference in the normalization content of services used to address the needs of mentally retarded adults, before and after the introduction of normalization as "policy."

Furthermore, the needs of de-institutionalized adults have not been met adequately by services used to address them.

More importantly, using Kerr's framework for policy analysis, it has been found that Normalization is a principle rather than a policy because it does not meet any of Kerr's conditions for policy, especially with respect to legislation and specification of implementation characteristics.
CHAPTER 6.0
SUMMARY, CONCLUSIONS AND IMPLICATIONS

This Chapter begins with a summary which reviews the purpose, the conceptual framework, methodology and findings of the study. Second, it presents conclusions, some concerning empirical data and some concerning normalization policy. Finally, it moves into the implications for normalization policy and for further study.

6.1 Summary

A basic purpose of the study was to explore the nature of normalization of services for previously institutionalized mentally retarded adults from Woodlands Institution. This purpose has been achieved through empirical data which generally show that services have been essentially deviant and consistent for the two groups of subjects studied. The study also shows that varying levels of normalization have been applied selectively to particular characteristics of services in a more or less random manner.

In defining normalization within the Greater Vancouver Region, explicit and implicit judgement of professionals and citizens were used to develop measurement criteria. Therefore the findings of this study are limited to Greater Vancouver Regions of British Columbia and the specifications of the study.

Another objective of the study has been to examine the
relationship between Community-based Services and individual needs of de-institutionalized adults from Woodlands. Using empirical data, it has been shown that a high percentage of additional services were provided to meet community needs for whatever reasons. Also, a proportion of identified needs were not provided with services. More importantly was the finding that lack of coordination exists in the delivery of services and identification of needs.

The study also aimed at providing data to aid decision makers in planning community based services. To achieve this, all of the empirical data have been tabulated in numbers and percentages to enable alternative analysis and inference from them.

Lastly, the policy of normalization has been analysed under an integrated framework. Thus, portions of empirical data has been used to support aspects of policy analysis. It has been found that normalization may not in fact be regarded as government policy towards mental retardation issues but a principle at best for which no specific implementation has been stated except as broad objectives.

Thus, all of the stated objectives for this study have been achieved, and hypotheses supported. In the process, conceptualizations of normalization, of policy, and of methodology have been borrowed from the fields of education and medicine.
6.2 Conclusions

From the study, the following general conclusions may be made:

(a) That in spite of the transfer of responsibility for mental retardation from the Ministry of Health to the Ministry of Human Resources, the process of service delivery remained essentially the same. Changes in terminology or the introduction of new forms of services have not reflected significant changes in direction or "policy" at least within the Greater Vancouver Regions.

(b) Services which had been used to address the identified needs of de-institutionalized retarded adults after discharge had been inadequate.

(c) The process of delivery of services for retarded adults within the study area had been uncoordinated at least, at the community level.

(d) There had been an increased use of social and medical services by subjects under the pre-normalization and the normalization periods.

(e) An important area of service inadequacy was vocational services. However, deficiency in terms of adequacy of service was found in all services excepting social services. In the latter, there seemed to be a tendency for identification of more needs for which services could be provided. This study did not look at the
qualitative aspects of services. It simply identified and scored them according to study criteria.

(f) Although mental retardation has been regarded as a social rather than a medical phenomenon, yet, linkages with the medical system continued to influence services. For example, social workers from Mental Health Services had responsibility for a majority of boarding homes.

(g) Services for mentally retarded adults within the study area had been essentially least normalizing or deviant.

(h) Normalization was not a 'policy' but a principle of the government and that normalization and de-institutionalization are separate and distinct entities.

6.3 Implications

The implications of this study are two fold: (a) Implications for policy making and (b) Implications for further research.

6.3.1 Implications for Policy Making

In general terms, the implications of this study with respect to policy making relate to the organization of community based services for mentally retarded adults. Although board statements of principle and objectives have been made, the central problem relates to the legitimization and implementation of the objectives. Assuming that in certain instances, a statement of principle may be substituted as authorization
for action, nevertheless, it is only when a principle has been converted to legitimate policy is it feasible to implement. Even then, the direction, extent and implementing agents/agencies would have to be specified.

Government policy statements are usually broad in nature. However, only when the policy statements have been legitimatized through legislation, for example, is it possible to make some forward progress.

The finding of lack of coordination of community based services is probably not new to decision makers. But from the standpoint of resources - human and material - it represents a significant waste of resources.

The study may suggest a reexamination of the activities of the volunteer sector in view of the high percentages of deviant services in volunteer section operated services. Having become involved with delivery of services, the volunteer or advocate sector has indirectly compromised its ability to seek the legitimization of normalization by Government. New policy directions may have to be developed in order to elevate the level of normalization in community based services.

6.3.2 Implications for Further Research

From the beginning, this study was stated as a process study. Therefore, there is a need to examine the outcome of the various intervention measures which have been developed as part of normalization.
A second area for study would be to examine the reasons for high utilization levels of medical and social services before and after the introduction of a social system of service delivery.

A third area for study may examine aspects of human right as they interface with normalization at general social levels and at individual levels.

A final area of study may be to examine alternative means for defining normalization or to use the methodology developed for this study in looking at different areas of British Columbia, different provinces or different societies.
BIBLIOGRAPHY

Anderson, T.P.  
Educational Frame of Reference: An Additional Model for Rehabilitation Medicine.  

Arhoff, F.N.  
Social Consequences of Policy Toward Mental Illness.  

Armour, W.D.  
The Needs of the Retarded Adult.  

Ashbaugh, J.A. & Bradley, V.J.  
Linking De-Institutionalization of Patients with Hospital Phase-Down: The Difference between Success and Failure.  
Hospital & Community Psychiatry, 30 (2) 1979, 105-110.

Bachrach, L.L.  
Planning Mental Health Services for Chronic Patients.  
Hospital and Community Psychiatry, 30 (6), 1979, 387-392.

Balla, D.A.  
Relationship of Institution Size to Quality of Care.  
A Review of the Literature.  

Bank-Mikkelson, N.E.  

Barr, M.W.  
Mental Defectives: Their History, Treatment and Training. Philadelphia: Blakiston, 1904.

Bassuk, E.L. and Gerson, S.  
de-Institutionalization and Mental Health Services.  

Bates, F.L.  
Changing Patterns of Care of the Mentally Retarded in Western Canada. (Special Report) Regina, Saskatchewan, 1977.

Baumeilster, A.A.  
Mental Retardation Policy and Research: The Unfulfilled Promise.  
Becker, H.S.
Outsiders

Begab, M.J.
The Mentally Retarded and Society: Trends and Issues.

Bell, N.J.
I.Q. as a factor in Community Lifestyles of Previously Institutionalized Retardates.

Black, H.C.
Black's Law Dictionary, 4th Edition (Revised)

Blatt, B. and Kaplan, F.

Birenbaum, A. and Seiffer, S.
Resettling Retarded Adults in a Managed Community.

Boulding, K.E.
The Boundaries of Policy: Strategic Perspectives on Social Policy.

British Columbia Association for the Mentally Retarded
The Status of Mentally Handicapped Citizens in British Columbia: A Report to the Social Service Committee of Cabinet.
Vancouver: May 14, 1981.

Brook, R.H. and Appel, F.A.
Quality of Care Assessment: Choosing a Method for Peer Review.

Brown, N.
Professor Labels Institutions Inhumane Warehouses.

Bruininks, R.H., Thurlow, M.L., Thurman, K. and Fiorelli, J.S.
Bush, R.T.
The Needs of the Intellectually Handicapped.

Butler, E., and Bjaanes, A.

Carter, C.H.
Medical Aspects of Mental Retardation.

Celdric Report
One Million Children.
Commission on Emotional and Learning Disorders in Children: A National Study.
CAMR, 1972

Chinn, P.C., Drew, C.J., and Logan, D.R.
Mental Retardation: A Life Cycle.

Clark, G.R., Kivitz, M. and Rosen, M.
A Transitional Program for Institutionalized Adult Retarded.

Clarkson, J.C.
Mental Health and Retardation Services in Manitoba: A Report to the Minister of Health and Social Development.

Clelland, C.C. and Sluyter, G.V.
The Heterobedfast Ward: A Model for Translating "Normalization" into Practice.

Close, D.W.
Community Living for Severely and Profoundly Retarded Adults: A Group Home Study.
Education and Training of the Retarded 12 (3) 1977, 256-262.

Cohen, H., Conroy, J., Frazer, D., Snelbecker, G, and Spreat, S.
Behavioural Effects of Inter-Institutional Relocation of Mentally Retarded Residents.

Conley, R.
The Economics of Mental Retardation.
Conrad, P.
The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behaviour.

Conroy, J.W.
Trends in De-Institutionalization of the Mentally Retarded.

Corcoran, E., and French R.
Leisure Activity for Retarded Adult in the Community.

Crawford, J., Aiello, J., and Thompson, D.
De-Institutionalization and Community Placement: Clinical and Environmental Factors.

Crichton, A.O.J.
Issues in Mental Health Services.
Class Presentation to Graduate Students.

Crichton, A.O.J.
Health Policy Making

Day, K.

Deutsch, A.
The Mentally Ill in America.

Donnellan, A.
Schooling a Right of Everyone.

Dror, Y.
Public Policy Making Re-examined.

Dror, Y.
Ventures in Policy Sciences - Concepts and Application.

Dworkin, R.
Taking Rights Seriously.

Edgerton, R.B.
Eni, G.
A Community Residential Plan for the Severely and Profoundly Mentally Retarded Adults: A Woodlands/Regional Pilot Project.

Erikson, K.
Wayward Puritans.

Eyman, R., Demaine, G., and Lei, T.
Relationship Between Community Environments and Resident Changes in Adaptive Behaviour: A Path Model.

Eyman, R., and Call, T.
Maladaptive Behaviour and Community Placement of Mentally Retarded Persons.
Ment. Ret. 82 (2) 1977, 137-144.

Eyman, R., Myers, D., and Tarjan, C.
Sociobehavioural Studies in Mental Retardation.

Eyman, R., and Borthwick, S.
Patterns of Care for Mentally Retarded Persons.
Ment. Retard. 18 (2) 1980, 63-66.

Faber, B.

Falta, P.
Beyond Tokenism
Housing and People 7 (2) 1976, 2.

Fiorelli, J.S. and Thurman, S.K.
Client Behaviour in More or Less Normalized Living Environments.

Fox, R.C.
The Medicalization and Demedicalization of American Society.

Fulton, R.W.
Job Retention of the Mentally Retarded.
Gil, D.G.
A Systematic Approach to Social Policy Analysis.

Gil, D.G.

Gittins, S.G.
Community Care The Myths and The Realities.

Glazer, D.
Social Deviance.
Chicago: Markham Press, 1971.

Goad, A.
Rejoining the Community Slowly
Vancouver: The Province, July 5, 1981.

Goad, A.
Working their way out of Society's Back Seat.
Vancouver: The Province, July 5, 1981.

Goad, A.
Inside Woodlands.
Vancouver: The Province, July 5, 1981.

Goffman
Asylums.

Goldberg, B.
Comprehensive Community Programming Revisited.
(Address to the 22nd Annual Meeting and Conference)
Ontario Association for the Mentally Retarded.
London: The University of Western Ontario, 1975.

Gollay, E.A.
An Analysis of Factors Associated with Community Adjustment.

Gottwald, H.
Public Awareness about Mental Retardation.
Gottleib, J.

Gottlieb, J.

Gove, E. (Ed)
Labelling of Deviance.

Greenblatt, M., and Glazier, E.
The Phasing Out of Mental Hospitals in the United States.

Grossman, H.J.
Manual of Terminology and Classification in Mental Retardation. (Revised Edition)

Gunzburg, H.C. and Gunzburg, A.L.
Mental Handicap and Physical Environment.

Gunzburg, H.C.
The Hospital as a Normalizing Training Environment in Gunzburg, H.C. (Ed) Advances in the Care of the Mentally Handicapped.

Hatcher, M., and Rasch, J.
De-Institutionalization and Community Based Treatment Alternatives.

Hawkins, R. and Tiedman, G.
The Creation of Deviance.
Columbus, Ohio: Chas. E. Merrill, 1975.

Heal, L.W., Sigelman, C.K., and Switzky, H.N.

Helsel, E.D.
- 213

-

Higginbottam, J .
D e - I n s t i t u t i o n a l i z a t i o n - A Canadian P e r s p e c t i v e .
Unpublished Manuscript.
R i v e r v i e w P s y c h i a t r i c H o s p i t a l , 19 81.
H o b b s , N.
The F u t u r e o f C h i l d r e n .
San F r a n c i s c o :
Jossey Bass,

1975(a).

H o b b s , N. (Ed)
Issues i n the C l a s s i f i c a t i o n of C h i l d r e n .
San F r a n c i s c o :
Jossey Bass, 1975(b).
Jay,

P.
Committee o f I n q u i r y i n t o M e n t a l Handicap
Care.
London:

Her M a j e s t y ' s S t a t i o n e r y O f f i c e ,

Nursing

and

1979.

J o n e s , K.
M e n t a l H e a l t h and S o c i a l P o l i c y 1845 - 1959.
L o n d o n : R o u t l e d g e and K e g a n P a u l , 1960.
Kahn, A . J .
T h e o r y and P r a c t i c e o f S o c i a l P l a n n i n g .
New Y o r k :
R u s s e l S a g e , 1969.
K a n n e r , L.
A H i s t o r y o f t h e C a r e and S t u d y o f t h e M e n t a l l y R e t a r d e d .
Springfield, Illinois:
C h a r l e s C. Thomas, 1964
Kerr,

Kerr,

D.H.
Educational Policy:
A n a l y s i s , S t r u c t u r e and
New Y o r k :
D a v i d McKay Co. I n c . , 1 9 7 6 ( a ) .

Justification.

D.H.
The L o g i c o f P o l i c y and S u c c e s s f u l P o l i c i e s .
P o l i c y S c i e n c e s 7, 1 9 7 6 ( b ) , 3 5 1 - 3 6 3 .

K e s s n e r , D., K a l k , C. and S i n g e r , J .
A s s e s s i n g H e a l t h Q u a l i t y - The C a s e f o r T r a c e r s .
K i n k a i d e , P.
Edmonton's D e v e l o p i n g Continuum o f R e s i d e n t i a l R e s o u r c e s .
D e f i c i e n c e M e n t a l e / M e n t a l R e t a r d a t i o n 27 (2) 1977,
8-14.
K i n k a i d e , P.
C o - o r d i n a t i n g t h e Edmonton R e g i o n ' s D e v e l o p m e n t and
D e l i v e r y o f C o m p r e h e n s i v e Community S e r v i c e s .
D e f i c i e n c e M e n t a l e / M e n t a l R e t a r d a t i o n , 30 ( 2 ) , 1980,
4-17..
K u k a s k a , C.
The D e c l a s s i f i e d R e t a r d e d :
I m p l i c a t i o n s of the
Definition.
T r a i n i n g S c h o o l B u l l e t i n , 7 1 , 1974,
5-8.

1973


Krasner, W.  
Labeling the Children: An interview with June Mercer.  

Kugel, R., and Wolfensberger, W. (Eds)  
Changing Patterns in Residential Services for the Mentally Retarded.  
Washington: President's Committee on Mental Retardation, 1969.

Larsen, L.  
Community Integration of the Severely and Profoundly Handicapped.  
John Hopkins University, and Dept. of H.E.W.  

Maloney, M.P. and Ward, M.P.  
Mental Retardation and Modern Society.  

Mann, D.  
Policy Decision-Making in Education.  

McCarver, R.B. and Craig, E.M.  

McDevitt, S.C., Smith, M.P., Schmidt, D.W. and Rosen, M.  
The DeInstitutionalized Citizen: An Adjustment and Quality of Life.  

McMillan, D.C.  
Mental Retardation in School and Society.  

Mental Defectives Act.  
Statute of British Columbia, 1953.

Menolascino, F.J.  
Challenge in Mental Retardation: Progressive Ideology and Services.  

Menolascino, F. and Eaton, L.  
Future Trends in Mental Retardation: Child Psychiatry and Human Dev.:  

Mental Health Act  
Mercer, J.R.
Labeling the Mentally Retarded.

Mercer, J.R.

Mesibux, G.B.
Alternatives to the Principle of Normalization.

Moen, M., Bogen, D., and Aanes, D.
Follow up of Mentally Retarded Adults Successfully or Unsuccessfully Placed in Community Group Homes.

Mooney, C.M.
Ottawa: Dept. of Nat. Health & Welfare, 1971

Murphy, H.B.M., Pennee, B. and Luchins, D.
Foster Homes: The New Backwards?
Canadian Mental Health Supplement No. 71. 1972.

Nelson, R.D., and Crocker, A.C.
The Medical Care of Mentally Retarded Persons in Public Residential Facilities.

Neufeld, G.R.
Approaches to DeInstitutionalization. In Paul, J.C., Stedman, D.J. and Neufeld, G.R. (Eds).

Neufeld, G.R.
Human Services: From Beliefs and Values to Direct Services.

Nihira, L., and Nihira, K.
From the Shadows to Success: A Survey of Successful Adapting by Community Placed Retardates.
Exchange 2' (3) 1974, 5-9.

Nihira, L. and Nihira, K.
Jeopardy in Community Placement.

Nirje, B.
Nirje, B.
Washington: President's Committee On Mental Retardation, 1969.

Olshansky, S.
The Deinstitutionalization of Schizophrenics: A Challenge to Rehabilitation.
Rehab. Literature, 41 (5-6), 1980, 127-129.

Ontario Public Service Employees Union (OPSEU)
Ontario's Mental Health Care Breakdown.
Toronto: OPSEU, 1980.

Platt, J.
Social Trap

Reich, R., and Siegel, L.
Psychiatry Under Seige: The Chronically Ill Shuffle to Oblivion.

Rhoades, C. and Browning, P.
Normalization at What Price?

Robinson, H.B., and Robinson, N.M.
The Mentally Retarded Child - a Psychological Approach.

Roos, P.
Normalization, De-Humanization and Conditioning - Conflict or Harmony?

Rothman, D.
The Discovery of the Asylum.
Boston: Little, Brown & Co., 1971

Rowitz, L.
Social Factors in Mental Retardation.
Social Science & Medicine 8, 1974, 405-412.

Rowitz, L.
A Sociological Perspective on Labeling in Mental Retardation.
Mental Retardation 19 (2), 1981, 47-51.
Rowitz, L.
Socio-epidemiological Analysis of Admission to State operated clinic for Retarded Children.

Rowitz, L.
Sociological Perspective on Labeling (a reaction to McMillan, Jones and Aloia)

Rubington, E., Weinberg, M.S. (Eds)
Deviance: The Interactionist Perspective. 3rd Edition.

Ryan, I. and Thomas, F.
The Politics of Mental Handicap.

Safilios-Rothschild, C.
The Social and Social Psychology of Disability and Rehabilitation.

Saranson, S.B., and Doris, J.
Psychological Problems in Mental Deficiency. 4th Edition.

Scheerenberger, R.C.
DeInstitutionalization and Institutional Reform.

Scheerenberger, R.C.
A Model for DeInstitutionalization.

Scheerenberger, R.C.
Mental Retardation: Definition, Classification and Prevalence.

Schur, E.M.
Labeling Deviant Behaviour.

Schur, E.M.
Interpreting Deviance.

Schur, E.M.
The Politics of Deviance.
Scull, A.
Museums of Madness: Social Organization of Insanity in

Shalock, R. and Harper, R.
Placement from Community-Based Mental Retardation Programs:
How Well do Clients do?
Am. J. Ment. Defic. 83 (3) 1978, 240-247

Shearer, A.
Handicapped Children in Residential Care. A Study of
Policy Failure.

Scheff, T.J.
Being Mentally Ill: A Sociological Theory.

Scheff, T.J.
Labeling Madness.

Sloan, W., and Birch, J.A.
A Rationale for Degrees of Retardation.

Smith, R.M.
An Introduction to Mental Retardation.

Spitzer, S.
Toward a Marxian Theory of Deviance.

Stacy, D., Doleys, D., and Malcolm, R.
Effects of Social Skills in Training in a Community
Based Program.
Am. J. Ment. Defic. 84 (2) 1979, 151-158.

Stein, L.I. and Test, M.A.
Alternatives to Mental Hospital Treatment.

Stevens, H.A.
Overview. In Mental Retardation. Stevens, H.A. and
Heber, R. (Eds).

Stevens, H.A., and Heber, R.
An International Review of Developments in Mental
Retardation.
Ment. Retard. 6, 1968, 4-23.
Stringham, B.L.
The School Act, 1970: A Case Study of Public Policy Making in Education.
Edmonton: -The Univ. of Alberta, Fall, 1974.

Suchar, C.S.
Social Deviance: Perspectives and Prospects.

Sutter, P.
Environmental Variables Related to Community Placement Failure in Mentally Retarded Adults.

Talbott, J.A.
Toward a Policy on the Chronically Mentally Ill Patient.

Talbott, J.A.
De-Institutionalization: Avoiding the Disasters of the Past.
Hospital and Community Psychiatry, 30 (9) 1979, 621-624.

Throne, J.M.
Normalization through the Normalization Principle: Right Ends, Wrong Means.

Tipperman, P.S. and Timeny, T.
Disease, Disability and Rehabilitation Consideration for Patient Care.

Titmuss, R.M.
Social Policy.

Tizzard, J.

Tropman, J. and Vasey, W.

Vail, D.J.
Dehumanization and the Institutional Career.
Vander-Zalm, W.
Living Independently for Equality: Project L.I.F.E.
A Plan of Independent Living for the Mentally Retarded.

Warham, J.

Warnock, H.M.
Special Education Needs.
Report of the Committee of Enquiry into Education of
Handicapped Children and Young People.

Wechsler, D.
The Measurement and Appraisal of Adult Intelligence.
Baltimore: Williams & Williams, 1958.

Whitmer, G.E.
From Hospitals to Jails: The Fate of California's
De-institutionalized Mentally Ill.

Willms, D.
Retarded Adults in the Community. An Investigation of
Public Attitudes and Concerns.

Willingston, W.B.
Present Arrangements for the Care and Supervision of
Mentally Retarded Persons in Ontario.
Toronto: Queen's Printer, 1971

Windle, C.
Prognosis of Mental Subnormals.

Wolfensberger, W.
Normalization.

Wolfensberger, W., and Glen, L.
Program Analysis of Service Systems.

Zipperlen, H.R.
Normalization. In Wortis, J. (Ed) Mental Retardation
APPENDIX A

(i) Certificate of Approval for research involving human subjects.

(ii) Letter requesting permission to obtain data from Institutional records at Woodlands.

(iii) Letter requesting permission to obtain data from Regional offices of the Ministry of Human Resources.

(iv) Letter requesting permission to obtain data from local offices of the volunteer sector.

(v) Permission from Ministry of Human Resources to engage in Study.

(vi) Sample of approvals from the Volunteer Sector to engage in Study.
February 4, 1981

Dr. P. Hughes  
Manager  
Woodlands  
Ministry of Human Resources  
9 East Columbia Street  
New Westminster

Madam:

Re: Permission to Obtain Data from Institutional Records for a Graduate Thesis

I am presently undertaking a study of previously institutionalized adults who are now living in the community. This requires data relating to their characteristics such as age, sex and level of retardation, as well as their needs prior to discharge.

I am, therefore, seeking permission to examine and collect data from the records of about 200 adults who were discharged between January 1, 1969 and December 31, 1970. Names of subjects will not be used in any recognizable manner and every attempt will be made to preserve confidentiality.

Data for the study will be gathered between February 25 to March 31, 1981.

Thank you.

Yours sincerely,

Godwin Eni

cc: Dr. P. Woodward  
Thesis Consultant
February 4, 1981

Mr./Ms.
Regional Manager
Region
Ministry of Human Resources

Dear Sir/Madam:

Re: Permission to Obtain Data for a Graduate Thesis from Regional Records and to Interview Regional/District Staff

I am presently studying some service responses to the needs of previously institutionalized retarded adults from Woodlands, who are now living in your community. This requires data relating to the services they are now receiving with support from your Region/District.

I am, therefore, seeking permission to examine and collect data from your records as the subjects are identified. Data will relate only to those adults who have been discharged from Woodlands between January 1, 1969 and December 31, 1970. Every attempt will be made to preserve confidentiality, and the names of subjects will not be used.

I am also seeking permission to interview some of your staff if and when data from records are incomplete. I hope to gather the relevant data between February 25 and March 31, 1981.

Thank you.

Yours sincerely,

Godwin Eni
February 4, 1981

Mr./Ms.
Executive Director
Association for the Mentally Retarded

Dear Sir/Madam:

Re: Permission to Obtain Data for a Graduate Thesis from your District Records and to Interview Staff

I am presently studying some service responses to the needs of previously institutionalized retarded adults from Woodlands, who are now living in your district and receiving services under contract or otherwise with the Region.

I am, therefore, seeking permission to examine and collect data from your records as the subjects are identified from the records at Woodlands. Data will relate to those adults who have been discharged from Woodlands between January 1, 1970 and December 31, 1979. I am also seeking permission to interview some of your staff if and when data from records are incomplete.

Every attempt will be made to preserve confidentiality, and names of subjects will not be used in any recognizable form.

I hope to gather relevant data from February 25 to March 31, 1981.

Thank you.

Yours sincerely,

Godwin Eni
(i) Letter to Members of Panel of judges

(ii) Definitions of Mental Retardation, Normalization and Selected Government's policy statements on Normalization.

(iii) - (ix) Closed questionnaires for panel of judges for specific service areas.
MENTALLY RETARDED ADULTS
LIVING IN THE COMMUNITY

1. DEFINITIONS:

Mental Retardation:

By "mentally retarded" we mean people similar to those who live in institutions for the retarded such as Woodlands in New Westminster. Some of these people have only moderate problems in intelligence while others have more severe problems. Over half of these people can communicate verbally and can eat and dress with little assistance. Very few have problems seeing or hearing and the majority can walk without difficulty.

Normalization:

The "principle of normalization" means "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."

2. STATEMENTS ON THE POLICY OF NORMALIZATION FROM THE MINISTRY OF HUMAN RESOURCES ANNUAL REPORT, 1975.

(a) "To return mentally retarded adults to their own homes or communities from the institutions."

(b) "...to participate in community life."

(c) "...to have right to economic security and opportunity to engage in meaningful occupation as determined by his or her capability."

(d) To have "equal human rights."

(e) To make available "community services to all citizens of British Columbia including the mentally retarded."
The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults.

Please check off (✓) one statement of each pair of statements that comes closer to your understanding of

A: Normalizing service or behaviours
B: Sub-normalizing service or behaviours
C: Least normalizing service or behaviours

RESIDENTIAL SERVICE

A. Normalizing

Mentally retarded adults should live independently or semi-independently in their own homes, family homes or apartments, in areas where most people live:

(i) ( ) With other non-mentally retarded adults.

(ii) ( ) With other mentally retarded adults.

B. Subnormalizing

Mentally retarded adults may live in boarding homes or group homes with six or less adults - where there is supervision with personal care or general care or minor assistance with housekeeping including scheduled programs:

(i) ( ) These homes may have combined or separate units for mentally retarded and non-retarded adults.

(ii) ( ) These homes may not have units for non-mentally retarded adults.

C. Least Normalizing

Mentally retarded adults should live in residences of six or more adults such as group homes, or nursing homes or institutions where there is medical, personal or physical supervision:

(i) ( ) These residences should not be separate from those for non-mentally retarded adults.

(ii) ( ) These residences should be separate from those of non-mentally retarded adults.
MENTALLY RETARDED ADULTS IN THE COMMUNITY

The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults.

Please check off (✓) one statement of each pair of statements that comes closer to your understanding of:

A: Normalizing service or behaviour
B: Subnormalizing service or behaviour
C: Least normalizing service or behaviour

SOCIAL SERVICE

A. Normalizing

(i) ( ) Mentally retarded adults should receive social services or social assistance available to all members of the community, at their request, without becoming self-supporting.

(ii) ( ) Mentally retarded adults should either be self-supporting, or at their request, should receive social services or social assistance which are available to all members of the community.

B. Subnormalizing

(i) ( ) Mentally retarded adults should receive special types of social services or social assistance after some specialized evaluation if they or their relatives or guardians request the services.

(ii) ( ) Mentally retarded adults should receive special types of social services or social assistance without specialized evaluation if they or their relatives request the services.

C. Least Normalizing

(i) ( ) Mentally retarded adults should receive specific types of social services or social assistance for mental retardation or for disability groups after some type of medical or social evaluation. Such services may be organized and managed for them where they live, or by a person or persons who are not relatives.

(ii) ( ) Mentally retarded adults should receive specific types of social assistance or social services for all disability groups without medical or social evaluation. Such services may be centrally managed by an agency, or a professional group.
The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults.

Please check off (✓) one statement of each pair of statements that comes closer to your understanding of:

A: Normalizing service or behaviour
B: Sub-normalizing service or behaviour
C: Least normalizing service or behaviour

**EDUCATION AND TRAINING SERVICE**

**A. Normalizing**

Mentally retarded adults and non-retarded adults:

(i) ( ) Should, together, receive their education and training in adult education classrooms and facilities within the community without modification of regular student programs.

(ii) ( ) Should separately receive their education and training in adult education classrooms and facilities within the community without modification of regular student programs.

**B. Subnormalizing**

Mentally retarded adults should receive special education and training in the community:

(i) ( ) In mixed regular and specialized educational facility with additional instruction or some modification of programs.

(ii) ( ) In separate specialized educational facility with additional instruction or some modification of programs.

**C. Least Normalizing**

Mentally retarded adults should receive specially designed education and training programs in specialized facilities including one to one courses:

(i) ( ) Offered in non-segregated classrooms

(ii) ( ) Offered in segregated classrooms.
MENTALLY RETARDED ADULTS IN THE COMMUNITY

The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults.

Please check off (✓) one statement in each pair of statements that comes closer to your understanding of:

A: Normalizing service or behaviour
B: Subnormalizing service or behaviour
C: Least normalizing service or behaviour

---

**VOCATIONAL SERVICE**

**A. Normalizing**

Mentally retarded adults should receive generic vocational services with non-mentally retarded adults in a community facility:

(i) ( ) Which is located in an industrial area of the community and which provides work placement or regular type employment after a minimum period.

(ii) ( ) Which is located anywhere in the community and which provides work placement or regular type employment after a minimum period.

---

**B. Subnormalizing**

Mentally retarded adults should receive vocational services with or without non-mentally retarded adults in a community or non-community facility which provides selected work programs:

(i) ( ) Services may advance graduates to regular type employment or work placement.

(ii) ( ) Services may advance graduate to special type employment or specific work placement.

---

**C. Least Normalizing**

Mentally retarded adults should receive specialized vocational services/training from special facilities which are self-sufficient and:

(i) ( ) Which advance mentally retarded adults to specialized work placement.

(ii) ( ) Which do not advance retarded adults to work placement.
The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults.

Please check off (✓) one statement in each pair of statements that comes closer to your understanding of:

A: Normalizing service or behaviour
B: Subnormalizing service or behaviour
C: Least normalizing service or behaviour

**RECREATION AND LEISURE SERVICE**

**A. Normalizing**

Recreation and leisure services for mentally retarded adults should involve a variety of individually preferred activities which take place:

(i) (✓) With non-retarded adults in community facilities.
(ii) ( ) With other mentally retarded adults in community facilities.

**B. Subnormalizing**

Recreation and leisure services for mentally retarded adults should involve some individually preferred activities which take place in the community:

(i) ( ) With separate activities for retarded and non-retarded adults in the same building, facility or area at the same time.
(ii) ( ) With similar activities for mentally retarded and non-retarded adults in separate building, facility or area at the same time.

**C. Least Normalizing**

Mentally retarded adults should receive specific and separate recreation and leisure services/activities/programs:

(i) ( ) In special facilities/area away from the community.
(ii) ( ) In special facilities/area in the community.
MENTALLY RETARDED ADULTS IN THE COMMUNITY

The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults.

Please check off (✓) one statement in each pair of statements that comes closer to your understanding of:

A: Normalizing service or behaviour
B: Subnormalizing service or behaviour
C: Least normalizing service or behaviour

---

PSYCHOLOGY SERVICE

A. Normalizing

(i) ( ) Psychology services for mentally retarded adults should be provided in professional offices which are located in designated agencies within the community and are available to non-retarded members of the community.

(ii) ( ) Psychology services for mentally retarded adults should be provided in professional offices which are generally located in non-designated agencies and are available to non-retarded members of the community.

---

B. Subnormalizing

(i) ( ) Psychology services for mentally retarded adults should be provided in the community but not accessible to non-mentally retarded adults.

(ii) ( ) Psychology services for mentally retarded adults should not be provided in the community but accessible to non-mentally retarded adults.

---

C. Least Normalizing

(i) ( ) Psychology services for mentally retarded adults should be provided in specific agencies, organizations or facilities for mental retardation and other disabilities.

(ii) ( ) Psychology services for mentally retarded adults should be provided in specific agencies, organizations or facilities for mental retardation only.
The following three pairs of statements summarize different feelings and behaviours about services which are made available to mentally retarded adults. Please check off (✓) one statement in each pair of statements that comes closer to your understanding of:

A: Normalizing service or behaviour
B: Subnormalizing service or behaviour
C: Least normalizing service or behaviour

MEDICAL SERVICE

A. Normalizing

(i) (✓) Medical services for mentally retarded adults should be provided by family physicians in the community chosen by the patient, or their families. The practices should provide for non-mentally retarded adults and seek specialized care through referral to specialists.

(ii) ( ) Medical services for mentally retarded adults should be provided by family physicians in the community chosen by professionals, such as a social worker, advocates, or friends. The practices should provide for non-mentally retarded adults and seek specialized care through referral to specialists.

B. Subnormalizing

Medical services for mentally retarded adults should be provided by:

(i) ( ) A physician or group of physicians-under arrangement with an organization, agency or with professionals-such as social workers-and have agreed to provide these services in the community with appropriate referrals to specialists.

(ii) ( ) A physician or group of physicians who live in the community but have agreed to provide services to retarded patients if their practice case loads decline.

C. Least Normalizing

(i) ( ) Medical services for mentally retarded adults are provided in mental retardation facilities, agencies or residences by a physician or a group of physicians on fixed salary.

(ii) ( ) Medical services for mentally retarded adults are provided in mental retardation facilities, agencies or residences by community based physicians under arrangement.
APPENDIX C

(i) Measures of Service: Criteria for Normal Scores

(ii) - (viii) Measures of Services

(a) Residential Service
(b) Social Service
(c) Education and Training Services
(d) Vocational Service
(e) Recreation and Leisure Services
(f) Psychological Service
(g) Medical Service
### MEASURES OF SERVICES

#### CRITERIA FOR NOMINAL SCORES

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>CRITERIA</th>
<th>SCORE</th>
</tr>
</thead>
</table>
| A. Normalizing or Therapeutic Service | a. Service or behaviour, i.e. applicable to all section of the community.  
b. Process cannot be distinguished from everyday behaviour or expectations of people in general.  
c. Service for process cannot be interpreted as unique to the mentally retarded or to any other group with disability in the community. | 3 |
| B. Subnormalizing or Maintaining Service | a. Service or behaviour may or may not be applicable to all sections of the community.  
b. Process may, to an extent, be distinguishable from everyday behaviour or expectations of people in general.  
c. Service or process may or may not be interpreted as unique to mental retardation or to any other group with disability in the community. | 2 |
| C. Least Normalizing, Custodial or deviant. | a. Service is distinctively controlling or applicable to mental retardation and/or other disability groups in the community.  
b. Process can be distinguished from everyday behaviour or expectations of people in general.  
c. Process and/or service are unique to mental retardation or to other groups with disability. | 1 |
MEASURES OF SERVICES

RESIDENTIAL SERVICE

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CRITERIA</th>
<th>SCORE</th>
</tr>
</thead>
</table>
| Nature of Residence | A | a. Own home  
b. Family home  
c. Apartment home  
d. Room and Board Boarding home | 3 |
| | B | a. Proprietary/Commercial Boarding home  
b. Group home with six or less adults | 2 |
| | C | a. Group home with seven or more adults  
b. Supervised residential care facility with seven or more adults  
c. Intermediate care facility - any size - with skilled medical supervision  
d. Nursing home  
e. Congregate care facility or institution such as prisons, psychiatric hospital or institution for the mentally retarded. | 1 |
| Type of Residence | A | a. Independent living in own home, family home, apartment or room.  
b. Semi-independent living in family home or apartment where dependence is for accommodation only. | 3 |
| | B | a. Supervised living - personal care.  
b. Supervised living and minor assistance with housekeeping.  
c. Supervised living personal, and general care including scheduled programs | 2 |
| | C | a. Dependent living - personal care.  
b. Dependent living physical care.  
c. Dependent living personal and physical care. | |
| Name of Residence | A | a. Name of residence - if given - cannot be interpreted as unique for a group with disability and/or mental retardation.  
b. Name is generic and indicate community services for everyone without differentiation. | 3 |
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CRITERIA</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>a. Name is ambiguous and may or may not be interpreted as unique for a group with mental retardation or other disability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Name reflects a purpose or indicates consumerism and/or advocacy.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>a. Name is specific or distinctive for a group with mental retardation or other disability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Distinct name is understood in local community as indicative of residence for groups with disability, such as the mentally retarded.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>(Arbitrary Criteria)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Location in a residential area of town or community - designated in accordance with local zoning by laws.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>a. Located in residential/commercial area of town or community with fewer non-retarded residents. (Except where the residents is a family home. The reason for location may be probed to assist scoring.)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>a. Residence is isolated from residential and/or commercial areas of the Community.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Residence is located in an industrial area of the community.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>a. Residence contains living units for retarded and non-retarded adults.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Living units are not physically separate or different from real home or apartment layout.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Units are similar in design and general appearance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Retarded and non-retarded adults live in the residence.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>a. Residence contains separate units for retarded and non-retarded adults.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Units are physically separate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Units are dissimilar in design</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Retarded and non-retarded live in separate sections of the residence ie. physical separation.</td>
<td>2</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>C</td>
<td>a. Residence and/or residential units are distinctively separate from those of non retarded adults in many respects - physically, or structurally.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Several living units have common access to an essential facility such as washrooms, sitting room study room, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL SERVICE**

| Nature of Social Service | A | a. self supporting | 3 |
|                         |   | b. welfare | |
|                         |   | c. GAIN - Guaranteed Annual Income for Need - without medical assessment or for short term benefit. | |
|                         | B | a. GAIN - with medical entry and assessment | 2 |
|                         |   | b. Specialized types of financial assistance which require means test | |
|                         |   | c. HPJA - Handicapped persons income assistance under GAIN | |
|                         |   | d. Homemaker services (social) | |
|                         |   | e. Counselling services - Adult support for handicapped or mentally retarded persons. | |
|                         | C | a. Comforts allowance | 1 |
|                         |   | b. Responsibility for social service benefits and its administration is centered in the management of the facility/home/residence in which the person lives | |
|                         |   | c. Absence of social support and services. | |

<p>| A | a. Self initiated by recipient for the provision of service which is available to the community at large | 3 |
|   | b. Has general entry - according to need - for all members of the community. | |</p>
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CRITERIA</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Social Service</td>
<td>B</td>
<td>a. Initiated by guardian, relative or friend</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Requires multiple entry - such as medical, social, educational and means.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>a. Initiated by social worker, a professional or by a facility or agency for mental retardation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Requires specific entry such as medical evaluation and/or diagnosis.</td>
<td></td>
</tr>
<tr>
<td>Name of Social Service</td>
<td>A</td>
<td>* Name of social service cannot be interpreted as belonging to a group with mental retardation or other disability</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Name of social service is ambiguous and can be interpreted as belonging to a handicapped or a non handicapped group</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Name is specific or distinctive with respect to disability groups or mental retardation</td>
<td>1</td>
</tr>
<tr>
<td>Location of Social Service</td>
<td>A</td>
<td>* Service or agency is located in offices which cater to the needs of all members of the community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Service or agency is located in offices which cater to the needs of disabled groups including the mentally retarded</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Service or agency is located in offices which cater to the needs of only mentally retarded adults and/or children</td>
<td>1</td>
</tr>
<tr>
<td>EDUCATION AND TRAINING SERVICES</td>
<td></td>
<td>* Community based adult education and training facility - in local education or training facilities supported by the community at large</td>
<td>3</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Nature of Educational Facility</td>
<td>B</td>
<td>* May or may not be based in the community but supported by volunteer</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>groups or government grants/subsidy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Based outside the community or in isolated areas of the community and supported by volunteer groups, or government grants/subsidy. Specialized facility</td>
<td>1</td>
</tr>
<tr>
<td>Type of Educational Program</td>
<td>A</td>
<td>* No modification from regular students' programs usually available in the community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Some modification of programs or additional instructions</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Specially designed programs for mentally retarded adults in disability</td>
<td>1</td>
</tr>
<tr>
<td>Name of Program or Facility</td>
<td>A</td>
<td>* Generic name - non specific connotation - name does not refer to a group with disability</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Name is non-generic and geared towards treatment and/or correction of</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deficiencies (such as opportunity workshops, community living skill</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>centres, and achievement centres) and not usually available to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>community members at large</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Name is specific for the mentally retarded or for a distinct group such as the mentally disabled</td>
<td>1</td>
</tr>
<tr>
<td>Location of Program</td>
<td>A</td>
<td>* Located within the community as for other adult education and training</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Located adjacent to specialized residential facility for the mentally retarded or other kinds of disability</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Located in a residential facility/environment for mentally retarded or disabled persons</td>
<td>1</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Integration Progressive Inclusion</td>
<td>A</td>
<td>* Full integration in community adult education classrooms, or education</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and training programs for retarded and non-retarded adults (Generic service)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Special education offered in a regular setting - ie, school or college</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Special education including one to one courses offered in a segregated setting</td>
<td>1</td>
</tr>
<tr>
<td>VOCATIONAL SERVICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>* Vocational service offers generic programs</td>
<td>3</td>
</tr>
<tr>
<td>Nature of Vocational Service</td>
<td>B</td>
<td>* Service offers selected work programs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Service offers specific and limited work programs</td>
<td>1</td>
</tr>
<tr>
<td>Type of Vocational Service</td>
<td>A</td>
<td>* Provides work placement or regular type employment after a minimum period</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* May advance graduates to special type employment or specific work placement</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Does not advance graduates to work placements outside of the environment</td>
<td>1</td>
</tr>
<tr>
<td>Name of Service</td>
<td>A</td>
<td>* Name of facility or program cannot be interpreted as unique to a group with disability</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Name has ambiguous interpretation and may not apply to disabled and not disabled persons</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Name is specific and distinctive for a group with disability.</td>
<td>1</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Location</td>
<td>A</td>
<td>Located in an industrial area of community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Located in a residential/commercial area except in instances where other industrial facilities are similarly located in the area</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Located in a residential facility or in isolation from the Community</td>
<td>1</td>
</tr>
<tr>
<td>Integration</td>
<td>A</td>
<td>Provides for all members of the community irrespective of disability or retardation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Occasionally provides for some non retarded or handicapped adults</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Specifically provides for mentally retarded or disabled adults</td>
<td>1</td>
</tr>
<tr>
<td>Nature of Service</td>
<td>A</td>
<td>Involves a variety of activities - three or more activities which are original and which take place in the Community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Involves less than two selected activities based on activities that are available in the community</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Involve specific activities for a definably specific group such as for disabled or mentally retarded persons</td>
<td>1</td>
</tr>
<tr>
<td>Type of Service</td>
<td>A</td>
<td>Activities are of individual preference</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Some activities are of individual preference</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Activities are pre-determined by caregivers and are not individual preferences</td>
<td>1</td>
</tr>
</tbody>
</table>

**RECREATION AND LEISURE SERVICES**
<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CRITERIA</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Service</strong></td>
<td>A</td>
<td>* Name of service/program/activity cannot be interpreted as unique for a group with disability or mental retardation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Name is ambiguous and could refer to handicapped or non handicapped groups</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Name is specific and/or distinctive for a group with disability or mental retardation</td>
<td>1</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>A</td>
<td>* Located in general community facility or area for recreation and/or leisure activities</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Located in areas or facilities which are occasionally available to handicapped persons for leisure or recreational activities</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Isolated from Community facilities/areas or located in or near the residence of a specific group with disability or activity does not take place in areas which are generally available to the community for such activities</td>
<td>1</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>A</td>
<td>* Fully integrated service and/or activity for all members of the community irrespective of retardation and/or handicaps</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Separate activities for retarded and non retarded adults in the same building, facility or area at same or separate times</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Separate activities in special facilities or area for retarded and non retarded adults in the community</td>
<td>1</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>PSYCHOLOGY SERVICE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nature of Service</td>
<td>A</td>
<td>* Service is provided in the community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Some service is provided in the community and some provided in specialized facilities/organizations/areas</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Service is provided in facilities/organizations for mental retardation</td>
<td>1</td>
</tr>
<tr>
<td>Type of Service</td>
<td>A</td>
<td>* Service is provided by individual psychologists in the community or by non designated agencies</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Some service is provided by designated and non designated agencies and private psychologists</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Service is provided by designated agencies/facilities/individual psychologists</td>
<td>1</td>
</tr>
<tr>
<td>Name of Service</td>
<td>A</td>
<td>* Name of service is generic and consistent with community psychology services/practices</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Name of service is ambiguous with respect to its reference to retarded or non retarded persons</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Name of service is specific for mentally retarded and/or disabled persons</td>
<td>1</td>
</tr>
<tr>
<td>Location of Service</td>
<td>A</td>
<td>* Service is located within the community in regular professional office accessible to members of the community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Service is located within the community but with occasional access for mentally retarded or disabled adults</td>
<td>2</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Integration of Service</td>
<td>A</td>
<td>Accessible to and utilized by non-mentally retarded or disabled adults</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Accessible to and utilized by mentally retarded or disabled adults occasionally</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Not accessible to or utilized by non retarded adults</td>
<td>1</td>
</tr>
<tr>
<td>Nature of Service</td>
<td>A</td>
<td>Service is community based</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Service is community and facility/agency based</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Service is agency/facility based</td>
<td>1</td>
</tr>
<tr>
<td>Type of Service</td>
<td>A</td>
<td>Family practice type of service with appropriate referral to specialists choice of practice/service by the client or his family</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Family or group practice by arrangement with an agency or facility or a professional</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>All services except specialist services are provided within or in the residence facility under arrangement or by permanent staff physicians</td>
<td>1</td>
</tr>
<tr>
<td>Name of Service</td>
<td>A</td>
<td>Name is generic for the community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Name is ambiguous with respect to client or patient group</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>Name is specific for mental retardation or a disability group</td>
<td>1</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>MEASURE</td>
<td>CRITERIA</td>
<td>SCORE</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Location of Service</td>
<td>A</td>
<td>* Located in a private office</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Partly located in a private office and partly in agency/facility</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Located entirely in an agency or facility for mental retardation or other disability</td>
<td>1</td>
</tr>
<tr>
<td>Integration of Service</td>
<td>A</td>
<td>* Accessible to an utilized by all members of the community</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>* Occasionally accessible to retarded adults</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>* Specially organized for mentally retarded persons or for disabled groups</td>
<td>1</td>
</tr>
</tbody>
</table>