

Part V: Toward New Service Models

Chapter 9

Small Special-Purpose Residential Facilities for the Retarded

Lloyd M. Dunn George
Peabody College for Teachers

	Page
Pros and Cons of Large Multi-Purpose Residential Facilities	213
Alternatives to Large Multi-Purpose Facilities	215
Some Types of Small Single-Purpose Residential Facilities	218
Medical Special-Purpose Facilities	220
Intensive Short-Term Treatment	220
Long-Term Nursing Care	221
General Medical Care	222
Nonmedical Special-Purpose Facilities	222
Child Development Centers	222
Boarding Schools	223
Rehabilitation Centers	224
Hostels	225
Concluding Comment	225
References	226

SMALL, SPECIAL-PURPOSE RESIDENTIAL FACILITIES FOR THE RETARDED

It seems to me that this is a most propitious time to do something about our residential centers for the retarded. Never before has the climate been better for experimentation with new approaches. Attitudes toward the retarded have improved. Legislators, citizens, the press, and the professions are far more aware of their responsibilities than has been the case previously. Attention to the problems and challenges of retardation has mounted at local, state, and national levels of government. Since a program for national action to combat mental retardation was submitted to President Kennedy by his panel on mental retardation in 1962, each of the states has completed a survey and evolved a state plan of services for the retarded. Today, many local communities are conducting their own studies to devise procedures to fit in with federal and state activities. Thus, the nation appears to be ready to embark on a greater thrust than in the past to provide quality residential services for the retarded. Therefore, it would seem an opportune occasion to explore various options for improving such services, to formulate plans of action, and to implement them. In this regard, my threefold thesis is this:

1. It is my contention that a century of failure of the large, multi-purpose residential facilities for the retarded (as we have known them) is enough; we need now to test the effectiveness of other procedures.
2. Further, it is my belief that we have the knowledge and ability to design and research these alternatives.
3. Still further, it is my hope that the efficacy of small special-purpose facilities will be examined as one of the alternatives.

Pros and Cons of Large Multi-Purpose Residential Facilities

The alleged advantages of the large multi-purpose center are well known. Such arguments as the following are included: It is usually the most inexpensive type of facility to operate. It should enable an interdisciplinary, team approach to diagnosis and treatment. It should provide multitasked treatment facility which would enable residents to obtain the most appropriate treatments needed at

The ideational and editorial suggestions of Wolf Wolfensberger are gratefully acknowledged.

a particular time. Large multi-purpose facilities should make possible comprehensive research programs. Furthermore, large residential facilities have high visibility for political purposes. Too, over the years, a handful of capable, dedicated professional personnel have devoted their lives to providing residential care to the retarded in such facilities. They have waged a constant fight against political pressures, penny-pinching taxpayers, and an ill-informed public. With such remarkable lack of support, it is a wonder they have been able to make our residential centers as good as they are. These people and their efforts deserve our support.

The many disadvantages of the large multi-purpose units are equally familiar. In reality, such units have usually tended to be custodial rather than intensive-treatment and rehabilitation oriented. It has long been recognized that institutional living prepares one for residing in such facilities rather than for return to the community. Traditional institutions have been so large that the personalized approach has been sublimated by impersonalized services. Competition and buck-passing among the various professional groups have been known to exist. In most cases, a pecking order among the staff has inevitably evolved to the detriment of the residents. Frequently, they have been operated on the medical model which views mental retardation as a disease, and has an emphasis on labeling and determining etiology; and once one has viewed mental retardation as a disease and affixed the label to an individual, one has a built-in, self-fulfilling prophecy. There has sometimes been emphasis on physical plant, at the expense of adequate staff and services. Too often, there has been exploitation of the more able residents at the expense of their rehabilitation. Furthermore, these large facilities have tended to be segregated from the community, and their staffs isolated professionally. Too, it has been difficult to attract and hold topflight professional personnel. Finally, much of the direct service has been provided by untrained attendants, while the professionals have largely found shelter and status in administrative tasks. Recently, in its "MR 67 Report," the President's Committee on Mental Retardation pointed out that many of our institutions are "plainly a disgrace to the nation and to the states that operate them." In a similar vein, the National Association for Retarded Children recently took the position that "despite much talk and some improvements in recent years, the quality of care of the mentally retarded in state residential institutions remains a national disgrace. There are very few states without back wards which they seldom mention when showing off a new building or a recently-inaugurated special program." Even more recently, Dybwad (1968) charged that the major roadblocks to improved residential care for the retarded are (1) "the medical model which insists on looking upon all institutional residents as patients, regardless of their actual condition," (2) "the view of the mentally retarded as a sub-human species for whom commonly-accepted standards of comfort, decency, and aesthetics need not be observed," and (3) "the power struggles and

lack of responsibility to the mentally retarded by the professions who claim to stake in the field." .

There are some who would suggest there is so much wrong with our present-day large, multi-purpose residential units that they should be abandoned. Certainly, evidence can be cited that retarded persons who remain in the community make greater progress than those who reside in institutions. As an example, the Cain and Levine study (1963) will be reviewed later in this paper. While I would suggest that we stop expanding or replicating institutions, I would be reticent to advocate their complete abandonment. Instead, we should continue to operate those in existence at least a little longer, with one of their major functions in the next decade being to provide a contrast treatment against which to evaluate other types of residential units. Perhaps with adequate support they can be greatly improved. It may be that research evidence will suggest a continuance of the large multi-purpose facilities for certain, if not for many, retarded individuals, if these units were operated in an optimal fashion.

Alternatives to Large Multi-Purpose Facilities

Because of the grave disadvantages of large multi-purpose facilities, I would recommend that we explore at least two alternative patterns. . . .

One is the small multi-purpose residence. From an examination of the 50 state plans for the retarded it would appear that this approach has high favor today. Generally, the notion is encompassed under the title "comprehensive community center." This arrangement does have a number of merits. It keeps the retarded in their home community. It tends to have a small number of persons in residence. Too, it provides flexibility between day and residential services. However, I am gravely concerned about these proposed comprehensive community centers. For one thing, they tend to favor the larger, urban communities--to the disadvantage of the rural, sparsely populated, and remote areas of our country. But more important, they will fail because sufficient top-flight professional manpower will not be available, in the foreseeable future, to staff them.

When the large multi-purpose residential facilities were initiated, many considered them the last word on the care for the retarded. But now many of us are disillusioned about them, and wonder whether they can succeed even with the most generous of support, since the system has within it the seeds of its own destruction. I predict that a decade or so from now, the advocates of small (multi-purpose facilities will be moaning over their failure to make good. Both types of multi-purpose facilities have the same type of major fault. They require a horizontal team with equal, high-level authority, status, training, and responsibility for all

the disciplines involved. But from whence are we to recruit these topflight cadres of professionals and how are we to prevent the interdisciplinary rivalry, power struggles, the dissension, the intrigue, and the buck-passing among them? Even a few such centers would tax a regional manpower pool. Thus, I cannot see how a complete range of quality services can be made available in these centers if they are proliferated across the nation, since each would require an array of professions across the different disciplines in order to succeed. In fact, I predict they, too, will degenerate into largely custodial units, staffed--if at all--in large measure by incompetent persons with professional paper credentials.

Some 4 years ago, Hobbs (1964) pointed out the same weakness in comprehensive, community mental health centers, but his warnings were not heeded. Now the staffing crisis is hitting these centers hard. It will be interesting to observe whether we, in mental retardation, are able to profit from the experiences of others, or whether we will fall into the same trap. Failure to recognize the long-term, chronic faults of the interdisciplinary approach, including the debilitating effects on services, is being ostrichlike. Our noble and bold proposals for comprehensive community centers for the retarded in every sizeable community in the nation, if implemented could become--by the year 2000--as sorry a set of facilities as our county workhouses of yesteryear. They could well work to the grave disadvantage of generations of retarded persons. The choice would appear to be between inferior services in small multi-purpose, community centers and superior services in small special-purpose facilities.

It seems to me that the small single-purpose units have much greater opportunity to succeed. However, they may have, in certain cases, the major disadvantage of removing the retarded persons further from their home community than would be the case with multi-purpose community centers. However, when I have faced parents with the hypothetical choice of placing their charge in a more distant center with intensive specialized treatment, in contrast with placement in a local facility with more general services, the choice--in the vast majority of cases--has been for intensive treatment. Too, with modern transportation, travel to even, a neighboring state is often not too difficult, and this would only be necessary for very rare and specialized treatments. Furthermore, we are rapidly becoming more and more urbanized as a nation, and thus a major proportion of families will live in densely populated areas that provide an adequate population base for specialized units.

The small special-purpose center has at least four advantages. First, responsibility is clearly assigned to the discipline which provides the specialized treatment. Thus, in a medical treatment center, a physician would be in charge; while in a child development center, a

child development expert would have ultimate responsibility, and so forth. Second, it is clear that interdisciplinary power struggles and bickering would be reduced sharply. Third, and very important, the centers would be oriented toward intensive and specialized treatments. Fourth, these small special-purpose units would reduce manpower needs. Instead of basing the operation of top-level horizontal teams of an interdisciplinary nature, these would use vertical teams. At the top of the pyramid would be the highly trained person in the profession, and under him layers of persons who would have gotten, as yet, less training--down to the novice and the technician. The opportunities here for inservice training become immediately apparent.

It is important to note that my bias in favor of the small special-purpose units is based on logic, philosophy, training, and past observations. What is lacking is much empirical evidence to support or refute my convictions. We cannot afford more bandwagons. Thus, my preference now is for carefully controlled comparative studies, wherein the optimal of treatments is provided in all types of residential units. These investigations should be conducted to determine the relative effectiveness of large versus small, and multi-purpose versus special-purpose residence types. The studies need to extend over a long enough period of time to enable us to acquire some solid evidence. At this point, no one type should be taken for granted as superior to the others. We need to find out how good the large multi-purpose facilities can be when adequately financed, staffed, and operated. Clearly, if sufficient quality professional technicians who are specialists in modifying the behavior of the retarded could be found to replace the present attendants, this might revolutionize the larger, present-day units.

It is a testable hypothesis that the small single-purpose facility will pay off best. Should this be the case, we could then begin to phase cut our present-day, catch-all facilities, into which we have crowded thousands of retarded persons of all ages, of all degrees of intellect, and with widely varying treatment needs. However, I should like to say again that evidence must be obtained on which to base our actions. It seems to me I have the right to argue my predilections, but I have an equal responsibility to await the evidence before pushing a wide-gauged implementation program. However, I recognize there are those who are opposed to awaiting research evidence before phasing out our present type of facilities. They argue that the efficacy studies will be inconclusive in that all the variables will not be controlled. Furthermore, they take the position that we should go ahead with different patterns even though we lack evidence, since we cannot possibly do worse than we have in the past. Furthermore, we have some evidence--especially from Europe--that small, new units will at least be better than large, entrenched, traditional facilities. As an example, Tizard's Brooklands experiment will be discussed later in this paper.

Another introductory point. As Dybwad (1964) pointed out so well, those who contend that we will eventually be able to do away with residential facilities for the retarded are very probably wrong. In the future, as never before, we will need additional residential facilities. Medical progress has upset nature's law of survival of the fittest, thereby possibly leaving us with more severely retarded cases than in the past. Atomic radiation is modifying human determination, usually in a deleterious direction. Urbanization, mechanization, and automation are reducing employment opportunities for unskilled laborers, and making society more complex. These factors, along with the great population increase, bring the problem of residential services for retarded persons into new prominence. Too, family disintegration, poverty's lack of adequate medical care, and other social ills are upon us. Thus, instead of needing less residential facilities, I believe that history will bear out my contention that residential units will need to increase rather than decrease in the future. In my view, what will be needed is a greater variety of residences. For example, as Dybwad (1964) has stated: "It stands to reason that so many different types of needs call for a number of clearly differentiated types of residential facilities, of different sizes, with different staffs, different buildings, and different programs." (p. 86)

No matter what type or types of residential facilities we elect for the future, we must do a better job of protecting the retarded person's constitutional rights to proper treatment and care. There have been many malpractices in connection with placement in residential facilities. We need to correct the last vestiges of our degrading commitment procedures, wherein we essentially put away retarded persons in our custodial institutions. We need also to correct our partially closed-door policies which violate the rights of parents and retarded persons to visit together, travel together, and live together whenever possible. There is something to be said for those who recommend wiping clean the legal and residential-care slate, and making a fresh start. There does seem to be a limit to changes which can be made after a century of entrenchment of an organizational structure based largely on the medical model. One advantage of new types of facilities would be that new practices could be initiated which might better preserve the constitutional rights of the retarded individual and his parents. In any event, competitive, alternative approaches should challenge those responsible for the operation of traditional facilities to make needed changes in their practices.

Some Types of Small Single-Purpose Residential Facilities

The second portion of this paper is devoted largely to outlining a few of the small special-purpose residential facilities with

which we might experiment. These are intended as examples. The list is far from inclusive. However, they should illustrate the principles for their operation which will first be proposed.

Below are enumerated these seven general principles upon which the units should be based:

1. The profession primarily trained to provide the needed specialized treatment should be in charge of the facility. Thus, a unit which is centered on vocational rehabilitation should be the responsibility of the vocational counselors. Similarly, a center designed to provide a special medical treatment should be the responsibility of physicians, and so on. While the profession providing the central, specialized treatment should be in charge, the other professions should be available in a secondary role when needed, but they must learn to play the role of consultants. Thus the responsibility and the rewards for providing a special-type treatment rest with the profession trained to provide that treatment. This should increase the recognition of both successes and failures. Thus, there should be much less buck-passing. Certainly, we need fewer chiefs and more Indians; professional personnel need to get out from behind their desks and "get their hands dirty." They need to be internally involved, firsthand, in the direct services rather than relying on untrained, ward attendants. (In my judgment, over 90 percent of the direct services to retarded residents in our present-day residential facilities are provided by the ward attendant, and less than 10 percent by the physician, psychologist, educator, speech therapist, social worker, vocational counselor, and recreation workers and the other professional groups.)

2. A flexible open-door policy is needed to permit an easy flow, between the community and the centers of professional personnel, of parents, of the public, and especially of the retarded persons themselves. Furthermore, this open-door policy should enable residents to be easily admitted to, discharged from, and returned to the facilities for short periods of time, when necessary. Too, whenever possible, these units need to provide service to retardates residing in the community.

3. The shifting of placement from one special-purpose facility to another should be easily accomplished. Residents should remain at a unit only while the treatment provided is effective and necessary. Anticipated in a continuum of care and treatment would be a variety of placements--depending on the needs of the residence at a particular time.

4. The number of residents in these special-purpose units should be kept as small as possible. For certain types of

facilities, this would often be from 10 to 50 persons. Seldom if ever would it exceed 100 to 200 residents – even when the treatment is less specialized and intensive.

5. When a number of similar special-purpose facilities are needed in a state, they should be distributed geographically, in keeping with population characteristics, so that the greatest number of residents can be as close to home as possible. For retarded persons who have the potential for employment in industry, the facility should be located near industry. Many would probably do well to be located near universities or other facilities which could provide professional services on a consultative and part-time basis.

6. Consideration should be given to the developments of inter state and regional facilities in cases of very specialized centers serving relatively rare conditions.

7. "Persons should be labeled as mentally retarded and segregated into special units only when essential for a special treatment. Otherwise the label should not be applied, and treatment should be provided from the mainstream of general professional services. Considerably under 1 percent of the general population needs to be so labeled and segregated. I believe that the labeling of 3 percent of the general population as mentally retarded is untenable.

Medical Special-Purpose Facilities. Of crucial importance is both general and specialized medical treatment. High priority should be given to providing every retarded person with optimal service, in its own right, and as a foundation for other treatments. While specialized medical approaches are still few in number, they are increasing rapidly. Thus the need for special-purpose medical facilities is likely to increase sharply in the years ahead. Medical services would appear to be of three types: (1) intensive, short-term medical treatments such as corrective surgery, comprehensive medical study, dental care, dietary or drug control, (2) long-term nursing care for chronic conditions, and (3) general medical care needed by all persons but by retarded persons to a greater extent. Each type of service will be discussed below.

(1) Intensive, short-term treatment. It would be my proposal that short-term, intensive medical treatment be provided at wings, wards, annexes, or institutes attached to medical schools, medical centers, and/or general hospitals, whenever possible. Better still would be to integrate the retarded person into medical facilities in keeping with his specific medical problem. For example, those with an endocrine dysfunction would be placed in a

ward at a hospital or medical center where endocrine problems are studied and treated. This process of integration would remove the likelihood of a person being stigmatized by having a low IQ score and a label of retarded when this is probably irrelevant to his treatment needs. The university-affiliated centers for the retarded--now supported by the federal government--may provide a useful pattern to study. However, another pattern might be small, narrowly specialized medical research and service centers. These might need to be established on an interstate and regional basis. For example, one regional medical center could have a focus on hydrocephalus, while another has a prime focus on a specific biochemical disorder, while still another could specialize in some other clinical condition. There might be a need to draw from several neighboring states to obtain sufficient rare cases. What this approach would do is provide intensive, specialized attention for a person with a particular condition. The limited number of experts available could be centered at these facilities. Of course, placing these specialized medical facilities adjacent to medical centers would likely result in at least some de facto affiliation, even if the facility is under a separate state, county, or city administration.

What are some of the advantages of such a special-purpose facility? Included would be better and more comprehensive medical services than are now generally found in our large residential centers, or are likely to be in comprehensive community centers. Available at a medical school would be a broad range of medical specialists and basic scientists. Such persons as endocrinologists, biochemists, geneticists, and physiologists could be involved in diagnosis and research. The retarded persons would be available to educate medical and nursing students in the care and treatment of the retarded. Thus there would be opportunities for developing more favorable attitudes toward, and knowledge about, the retarded than has been the case in the past on the part of most medical personnel. Physicians and nurses in such settings probably would have better pay, more stimulating conditions of employment, less isolation, more consultation and a greater challenge than would be the case in isolated traditional institutions.

As already indicated, responsibility for the special-purpose, medical programs clearly would rest with the medical and paramedical professions. The type of persons to be served and their treatment would determine whether the prime responsibility should rest with pediatricians, neurologists, neuro-surgeons, etc.

(2) Long-term nursing care. The best method for providing long-term nursing care for the chronic cases is difficult to discern. Whenever possible, the retarded should receive regular nursing home services. This should be especially feasible in the case of senescent retardates in that old age is a great leveler. In terms of

functioning capacity, there will often be little difference between the 85-year old who was a college professor and the one who has been intellectually retarded all of his life. Furthermore, this would enable the aged to be in their home communities.

In the case of chronic bed cases originating in childhood, again the notion of a unit as a part of, or at least adjacent to, a medical center, or college, or at least a general hospital would appear to have merit.

(3) General medical care. Finally, it needs to be pointed out again that retarded persons need good general health services as do all citizens, even more so. These should be available on call at all times, no matter what the type of residential facility in which the retarded is placed. Generally, it is probable that the best such services would be obtained through contracting with physicians in the community, in medical centers, in hospitals, if not in private practices.

The foregoing remarks are intended only to provide a point of departure in thinking through improved medical services for the retarded in a residential setting. Clearly, the medical disciplines with the expertise in this area will need to propose their own patterns.

Nonmedical, Special-Purpose Facilities. Below are a few small special-purpose, nonmedical units which may be worthy of consideration. It is my best estimate that about 90 percent of the present treatment for the retarded, in day and residential settings combined, is nonmedical in nature. Thus, the ratio of nonmedical to medical-special units needs to be in the ratio of approximately 9:1.

(4) Child development centers. Child development centers need to be provided for the severely retarded but ambulatory children, with IQ scores approximately 20 to 40, who cannot be served on a day care basis. Such centers might best serve children on a 5-day week schedule, but 7-day services may need to be provided for selected cases. The parents and professionals need to coordinate their efforts so as to foster optimal development of the children. A major goal would be to establish self-care and social skills. In large measure, learning would be programmed on the typical instrumental act paradigm wherein a drive would lead to an appropriate reward through a predetermined, useful instrumental act. Behavior could be shaped in reaching for objects, sitting up, eating, communicating, dressing, walking, opening doors, playing, and so forth. Research to date on the effectiveness of such procedures has led to two conclusions: (1) Even the profoundly retarded can learn much more than we had thought possible, (2) There is little relationship between IQ scores of low-functioning persons and their ability to

learn operant conditioning. The prime advantage of such child development centers would be to move us from our present custodial, defeatist approach for the more severely retarded to treatment-oriented procedures aimed at developing as many independent living skills as possible. The special-purpose units could well be under the direction of experimental psychologists skilled at operant techniques. Of course, other child development specialists would be involved.

(5) Boarding schools. Such schools are needed for a variety of school-aged retarded children. For example, mildly retarded children from rural areas might need such a facility for a 5-day school week. Too, such a facility may prove superior to our current special day classes for moderately retarded children with IQ scores roughly 40 to 60. In this latter case, approximately one-third of the children enrolled might be mongoloid, one-third of them neurologically impaired, and one-third mentally retarded due to rare and/or unknown causes. In the past 20 years, parent groups have mobilized as never before to keep such boys and girls out of our large multipurpose residential facilities for as long as possible. They have encouraged the establishment of special day schools and classes in local communities, but these have not worked well for a number of reasons, including the shortness of the treatment, which usually extends for only 3 or 4 hours a day of actual instruction, at the most, and for only 180 days a year. Soviet special educators, in learning of our special day schools and classes, have observed that only through boarding schools which operate around the clock and calendar with both school and after-school instructors are the children likely to develop adequately.

There is some evidence that neither our school programs in large residential facilities nor our community special classes are working very well. For example, Cain and Levine (1963) have compared the relative effectiveness of four types of treatment for the trainable mentally retarded. One group lived on the wards of a large residential facility. The second and similarly institutionalized group attended the school at the institution. The third group lived in the community and attended, special day classes. The fourth group also lived in the community, but remained at home with their parents without receiving any special education services. Four major findings of this study were as follows. First, both special day class children and children remaining at home made better progress in social competence than their counterparts in residential facilities. Second, special day class training, as presently constituted, was no more effective than the informal training provided when the child remained at home. Third, both those of the wards and those attending school at the large residential facility decreased in social competence; apparently attending school in a residential facility is not

sufficient to overcome the negative effects of institutionalization. Fourth, great variability existed in the special day class training programs; a few teachers provided a sequential, meaningful curriculum which proved quite effective, while many others were primarily providing day-care, baby-sitting, and recreation services.

The Brookland's experiment conducted by Tizard (1962) in England provides evidence in support of the small boarding school. He and his associates compared two groups of trainable mentally retarded children, one in a large multi-purpose institution, the other in a small home-like boarding school located on a small estate and under the direction of kindergarten teachers and child development personnel. The small boarding school proved significantly superior for the children.

These two studies, when viewed together, suggest the need for small boarding schools for the moderately retarded. While such units would provide boarding facilities on a permanent basis for a few children, much more frequently the children would be boarded at the facility only through the workweek, returning to their homes on weekends. Further, these centers would provide day facilities for some children who would be brought to them in the morning and picked up again in the evening by the parents. Thus a combined community and residential facility is proposed. Such units should be the professional responsibility of kindergarten teachers and/or special educators, if not a new professional group which might be labeled child developmentalists.

(6) Rehabilitation centers. A variety of different types of rehabilitation centers are suggested for young adults in their teens and twenties who are referred to residential facilities for the first time because society or the home can no longer tolerate their behavior. These young adults of usually moderate retardation and borderline intelligence will have exhibited management problems such as delinquent acts and promiscuous sex behavior, or will lack saleable or social skills to enable them to exist in our increasingly complex and difficult society. My suggestion would be that most of these young people are rehabilitation problems. Therefore we should turn to vocational counselors, clinical and counseling psychologists, and group social workers to rehabilitate them. These professions need to design, foster, and operate a series of rehabilitation centers, with different foci, for these teenagers and young adults. It would seem desirable that the size of such facilities be quite small, perhaps numbering, at one time, no more than 10 to 50 residents. Services at such units would center on rehabilitation, counseling, sheltered work, teaching vocational skills, providing a home, structuring behavior, and providing a temporary haven in times of community and home crisis. Thus, these special facilities need to have minimum flexibility. They need to provide a boarding facility

for persons in residence—both for those who are full-time residents, and for those who live at the facility and have secured competitive community employment but are not ready for complete independence. Too, they need to provide shelter, on a day-to-day basis, for persons who may have been at the facility some time in the past and are returning to mobilize their potentials so as to return to society. In this regard, they need to function in many respects like our old half-way houses. Furthermore, some of them need to give service to members of the community who spend their days at the facility for protective purposes and for learning vocational skills while living at home. Certainly the key to the success of such facilities would be an "open-door policy," if rehabilitation is to have meaning.

(7) Hostels. Such residences are suggested for retarded adults who have no home and whose primary problems are not medical. These persons will usually be in the moderately retarded to borderline intelligence range, with chronological ages extending from young adulthood to senescence.

These hostels would emphasize self-care, economic productivity, recreation, effective use of leisure time, and socialization. Here professional responsibility would rest primarily with group social workers, though other group specialists might be considered. The idea would be to develop small special-purpose facilities on the cottage plan, as has been done for years in certain European countries. It may be that these individual cottages would serve as few as 6 to 12 persons. They might well be located in small towns, as has been the case in many of the Lowland Countries in Europe where the community or village is dedicated to the care and welfare of the retarded adults as a community enterprise. Such facilities probably should be on spacious grounds with the central buildings providing sheltered workshops as well as dining and recreational facilities. Community physicians and hospitals would provide the needed health services.

Concluding Comment

It has been my plea that the virtues of small special-purpose residences be considered carefully in contrast to small multipurpose community centers and large traditional multi-purpose institutions. Clearly a wide array of residential services will need to be devised if retarded persons are to have quality care and treatment now and in the future. The exciting thing is that society appears ready to try out different patterns of services, shaped to the emerging social order, so that we can begin to correct our inexcusable errors of the past.

REFERENCES

- Cain, L.F., and Levine, S. Effects of Community and Institutional School Programs on Trainable Mentally Retarded Children. CEC Research Monographs, Series B, No. B-1. Washington, D.C., 1963.
- Dybwad, G. Challenges in Mental Retardation. New York: Columbia University Press, 1964.
- Dybwad, G. Roadblocks to Renewal of Residential Care. Paper presented at the 4th International Scientific Symposium on Mental Retardation of the Joseph P. Kennedy, Jr., Foundation held in Chicago, Illinois, April 29, 1968.
- Hobbs, N. Mental Health's Third Revolution, American Journal of Orthopsychiatry, 1964, 34, 822-833.
- National Association for Retarded Children, A Needed Next Step in Implementing the Federal Role in Improving Residential Care for the Retarded. New York: NARC, 1968.
- President's Committee on Mental Retardation. MR 67: A First Report to the President on the Nation's Progress and Remaining Great Needs in the Campaign to Combat Mental Retardation. Washington, D.C.: U.S. Government Printing Office, 1967.
- Tizard, J. The Residential Care of Mentally Handicapped Children. Proceedings of the London Conference on Scientific Studies on Mental Deficiency, 1962, 2, 659-666.