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Many human management systems have residential components. In some fields, these are minor, e.g. in lower education; in others, they are major. Particularly, there are four areas of human management in which residential services are a major component – if not in terms of the proportion of individuals served, then at least in terms of their sheer numbers nationwide, and in terms of the significance of residential services in the tradition of the area. These four areas are mental retardation, mental disorder, geriatrics, and correction. However, it is amazing how similar residential service problems are, regardless what group of clients is involved: the retarded, disordered, blind, deaf, delinquent and legal offender, aged, orphaned, homeless, etc. It is also surprising how powerfully the normalization principle can apply to residential services in any area, underlining once more both the universality as well as parsimony of the principle.

Other chapters in this book have touched upon normalization implications to residential services, especially so the preceding one. However, some points relevant to residential services bear repeating or elaborating, and additional ones need to be presented.

Residential services can be subdivided into individual and group placements. Individual placements would include adoptive, foster, or boarding homes for one person, or at most a very few. Group placements would include boarding schools, most jails, institutions, hospitals, etc. One general difference between individual and group placements is that the individual placement involves a home that has the primary purpose of housing one or more additional persons who are adults and who do not provide domiciliary services to others as a primary pursuit. In contrast, most group residences exist primarily for persons under human management. Those who work there and perhaps live there do so primarily in order to serve the group residents. This is a statement one could not even make about a mother of ten children, even if her home were large.

Individual placement into culturally normative homes presents some normalization challenges, and some of these will be covered later in this chapter. However, far greater challenges, almost inseparable from architectural ones, are presented by group settings which will be covered first. Too often, group residences are institutions, and we need to distinguish clearly in our minds between institutional and other group residences.

Normalization implications to group residences

WHAT IS AN INSTITUTION?
Both the 5,000-place institution as well as the 5-place hostel are residential services; what makes us apt to label one as an institution, and the other one
as something else? Obviously, definitions are arbitrary. We are free to define institutions in such a way as to reflect the typical citizen's opinion of what an institution is; we can impose an arbitrary definition that is more scientific or technical; or we can combine elements of both approaches.

Goffman (1961) rendered a brilliant analysis of what he called 'total institutions', which he defined ultimately in terms of the barriers which exist between them and the outside, especially the barriers to departure. I suspect that even without awareness of this definition, most citizens today would similarly define an institution largely on the basis of features that emphasize separateness from the community mainstream. Yet, as attractive and useful as this definition has proven to be, I feel that such a barrier is merely a common rather than essential feature of an establishment that might be defined as a total institution, and that appears to typify so many of our traditional human management residential services. It seems to me that ultimately, an even more useful definition would be based on the deindividualization that permeates the atmosphere of a residential community. More of the features commonly associated with an institution appear to be corollaries of deindividualization than of separation from the 'outside'. Such corollary features include the following.

An environment that aims at a low common denominator among its residents – for instance, because a few or occasional residents may be unstable or destructive, all residents may be subjected to an environment that appears necessary and/or appropriate to the few or occasional ones. We are all familiar with the locked doors, heavy-duty construction and furnishings, and socio-behavioral surveillance, structure, and restrictions imposed on a group for the sake of a few of its members. That deindividualization can be a more significant feature than confinement is apparent from the fact that physical restraints, even when used, are usually quite unnecessary and often even ineffective in maintaining separateness and confinement.

Congregation of persons into residential groups larger than those typically found in the community – in North American society, the most typical grouping residing together in the community is the nuclear family, which rarely exceeds six to eight members.

Reduced autonomy of residents, and increased regimentation, generally including mass movement and mass action on the part of the residents, and regimentation of their routine – again, very extensive regimentation can be attained even when there is no physical and even little social barrier to departure. The voluntary deindividualization, regimentation, and separateness of monasteries is a good example.

Ordinary citizens sleep, study, work and play in separate contexts and settings, and in each setting, they tend to interact with a different group of fellow citizens; in institutions, these settings tend to be physically fixed under one roof or on one contiguous campus, and sometimes programmatically unified in terms of environmental and supervisory structures. Also, the same group of persons tends to interact with each other in each such setting, resulting in an inward directedness. Again, these features greatly reduce opportunities for individualization.

Thus, it is necessary to distinguish between institutions and other group residences. In the subsequent discussion, the term institution refers to a deindividualizing residence in which persons are congregated in numbers
distinctly larger than might be found in a large family; in which they are highly regimented; in which the physical or social environment aims at a low common denominator; and in which all or most of the transactions of daily life are carried out under one roof, on one campus, or in a largely segregated fashion.

**FIVE MAJOR IMPLICATIONS OF NORMALIZATION**

Aside from innumerable fine points of programming, the normalization principle suggests or even dictates that group residential services have certain gross characteristics, among these being integration, smallness, separation of the domiciliary function, specialization, and continuity, all to be discussed below.

**Integration**

In many provinces, states, and countries, a large percentage of residential services is provided either in relatively isolated areas, and/or far away from major population centers. Obviously, such a situation violates the principle of integration which demands that residential services, like all services, generally need to be community-integrated and dispersed so that residents will intermingle with typical citizens in typical activities.

The above needs to be considered carefully in deciding upon the nature and location of a residential unit or complex. For example, residential units generally should be within easy walking distance to major community services such as shopping centers, public libraries, post offices, churches, schools, and recreational resources such as movie houses, bowling alleys, etc. They should also be accessible to various transportation alternatives to facilitate entry in and contact from the community, and they should have ample parking. Unfortunately, many current residential services, even if located very favorably, still encourage segregation rather than integration of residents.

So much has been said about integration in this book that little needs to be added, except to reemphasize the profound implications which the integration goal has on the type of client grouping, and on group and facility size.

**Smallness**

A problem of concern in many countries of the world is the typically large size of residential facilities in many fields, especially in mental health and mental retardation. In this regard, the following points are now increasingly accepted (e.g. Fairweather, Sanders, Maynard, Cressler, & Bleck, 1969; Ullmann, 1967).

Large size does not necessarily result in economy of operation. Sometimes, large size results in uneconomical operations. Large facilities result in inward rather than outward direction of both resident and staff socialization, and therefore they foster insulation from society, 'institutionalization' of attitudes and behavior, and often result in longer duration of stay of residents.

If it is desired to create an atmosphere of continuity between a residential service and the local community, then a residential facility should have no more residents than the surrounding community can readily
'absorb' in terms of recreation, transportation, shopping, socialization, and tolerance of perceived deviancy. The management of large numbers of individuals, especially if these are of reduced behavioral adequacy, is difficult and perhaps impossible without regimentation and loss of individuality; thus, in large facilities, dehumanizing management tends to develop. Even by itself, the goal of integration almost automatically implies that services, and especially residential services, be small, since neighborhoods and communities cannot absorb large numbers of deviant individuals. Exempted to some degree from this principle are certain generic residential services whose clients are not perceived as deviant, e.g. general hospitals, and residential services which, by their nature, cannot or must not aspire to integration, e.g. detentive facilities.

Separation of the domiciliary function
A major residential corollary of normalization is the separation of the domiciliary function. In the mainstream of society, a residence is merely a domicile, and formal education, work, medical treatment, and many recreational, social, and friendship transactions are carried out elsewhere in places such as schools, training centers, offices, clinics, churches, playgrounds, bowling alleys, bars, etc. Since these locations are typically separate from the residence, the same separation should be attained for human management residences, if at all possible. Thus, when we offer residence, treatment, education, work, religious nurture, and recreation all on one campus (as we commonly do in residential treatment and service centers), or even under one roof, we often denormalize. In fact, when we also offer virtually total medical care as well as a significant amount of restriction, then we have fused the roles of community, home, school, hospital, and jail into one single entity, and too often, the lowest common denominator — usually the jail elements — prevails and sets the tone for everything else.¹

There appear to be only two types of residential services in which the domiciliary function must be fused with other types of management. One is for individuals who require major medical services (perhaps actual maintenance of life) which necessitates that typical non-domiciliary transactions be brought to or near the bed. The second is for individuals requiring detention. Even among groups whose behavior may be very significantly impaired, e.g. the mentally retarded and disordered, there are very, very few persons who would fall into either of these two categories.

Separation of the domiciliary function is one more expression of the management concept that human services should not provide more support and shelter than a client needs. Too often, when a person needs support or shelter in one sphere of his functioning, human management services have supported and sheltered several or all. Again, institutional practices are an

¹ Just as these lines were being written, I experienced a poignant reminder of the almost invariably unconscious mixing of models that should not be mixed unless unavoidable. I received an advertisement from a residential center which defines its goals as 'medical, educational and residential care of handicapped infants and children'. The word 'detentive' was missing — but the picture showed a brown brick building in what appeared to be a rustic setting, with a sturdy fence around it.
example: because a person may have needed a sheltered domicile, he was not only given such domicile in the institution, but was usually also separated from his ordinary school or work, his recreation, worship, and many other societal functions. In the institutions, these functions were often denied; provided in a sheltered, controlled, and segregated fashion; or conducted in societally non-normative fashion.

To offer all services under one roof is convenient — although not always as economical as claimed. However, this convenience should be sacrificed if a useful principle is at stake. We should ask ourselves at all times whether any service provided in conjunction with a residential service would not be provided in a more normalizing fashion by drawing on extra-residential and community resources, thereby increasing the resident’s integration and habilitation.

Thus, among other things, the normalization principle demands that as few central services as possible be provided as part of a residential unit. In other words, professional offices, educational space, treatment areas, etc. generally should not be in the same building that serves as a home. Residents should go to regular community resources and services, such as kindergarten, school, other education, shopping, most medical and professional services, movies, bowling, swimming, and most other recreation. Only to the degree to which no alternatives are possible should such services be provided even on the same ‘campus’.

Specialization

Specialization of the residential management model has many normalizing features. For instance, it helps in the separation of the domiciliary function. Also, it separates age groups to some degree; in society, we rarely find individuals of divergent age groups living in one home, except within nuclear families. Indeed, the nuclear family of today rarely even spans more than two generations. In order to individualize management, specialization also separates those groups that require entirely different types of environment. For instance, it imposes the medical model only upon those who definitely need it. Further specialization reduces other undesirable types of heterogeneity of client groups. To repeat an earlier example, in many of our institutions, those who need detention or a high degree of structure and supervision are housed in the same living units as those who do not, but because of the needs of the less advanced residents, all residents are subjected to a high degree of structure, supervision, and perhaps even detention. This is merely one instance of the type of protective overkill that is common in many deindividuated heterogeneous groupings. Finally, in many areas, specialization is the only way to operate small facilities economically.

As desirable as the specialized model is, managers should remain alert to the need to integrate residences as much as possible into the community. In fact, there is no reason why many residences cannot be specialized as well as integrated. Despite my objections to the term ‘halfway house’, and its commonly associated conceptualization of a very limited range of residential options, the book by Raush and Raush (1968) on this topic documents a number of systematic attempts to integrate clients with other citizens in residential settings.

Further details on the residential specialization concept are available in
Dunn (1969), Dybwad (1969), Governor’s Citizens’ Committee (1968a, 1968b), Menolascino, Clark & Wolfensberger (1968, 1970) and Wolfensberger (1969c). I will return to this topic in the next chapter.

**Continuity**

In order to make a specialized system of small domiciliary units work, there must be continuity between different types of residences, and between domiciliary and nondomiciliary functions. In some instances, this will imply an administrative continuity which assures program continuity.

A continuum of living facilities will provide many more options than exist now, so that individuals can be moved along the continuum of supervision as needed, and in either direction. Thus, an adult client may start out under intensive observation and in individual and group management at a central facility. He might then be moved to a hostel from which he attends a community sheltered workshop half-day, spending the other half-day in an intensive personal management program at the central treatment facility or some other meeting point. Eventually, he may move to another hostel which he leaves every day for competitive employment, until he becomes fully independent in both work and residence.

Conversely, an adult with minor impairment may come to live at a minimal supervision hostel while continuing to hold his regular job. If he becomes more impaired, he may be moved to a more intensively supervised hostel or even a central treatment center.

The vast majority of chronically and severely impaired persons who make up the long-term residents of our public institutions are ideal candidates for sheltered community hostel living. Some require the services of hostels that function much like nursing homes. Others could be infinitely better served than they are now by living in hostels from which they (if they are adult) attend all-day sheltered work. The waste of human resources practised by our institutions is socially inexcusable.

Too often, the literature refers to halfway houses, or even ‘the’ halfway house, as covering the gap between institutional and independent living. Such a conceptualization is clearly inadequate. It will take different types of intermediate residences in different fields, but in some fields (mental retardation, mental health), more than a dozen types each are needed.

**Concluding statement regarding the five major implications**

It can be seen that the above corollaries of normalization are intimately interrelated. Integration requires smallness, which implies both dispersal and specialization. All three require a separation of the domiciliary function. Specialization further implies a continuity of options, also required by individualization of management which, additionally, needs continuity of movement and function between different types of services.

**SPECIAL CONSIDERATIONS FOR DIFFERENT AGE GROUPS**

**Residential services for children**

Residential services to children generally should be clearly separated from services to adults. To serve both children and adults in the same facility is
increasingly recognized as having many drawbacks. It does not parallel most accepted patterns of analogous services to individuals not defined as deviant in society; and to treat deviant children and adults in the same context provides the children with inappropriate adult models and, on the other hand, diminishes the dignity of the adult resident by casting him into a role not sufficiently demarcated from a childlike one.

If at all possible, residential treatment services for children should be based on small home-like units of four to eight children each. Normalization principles would strongly suggest that these units function in typical family homes or apartments. A ‘ward’ is a poor substitute for normality. A compromise for some circumstances is a complex of cottage-like units, or use of multiple apartments in an apartment house.

Also, if at all possible, most children’s residences should have live-in houseparents as the primary contact personnel, rather than a series of persons, often with limited job stability, rotating through three shifts a day and various weekend and relief shifts. If a houseparent system is not possible, a compromise between the houseparent and the traditional shift system should be established, as exemplified in Project Re-Ed for disordered children (e.g. Bower, Lourie, Strother, & Sutherland, 1969; see also the entire March 1969 issue of Mind over Matter). Traditional, essentially hospital-derived, shift systems are extremely unsatisfactory for children, although some type of shift system can work very well if it is superimposed upon a houseparent or at least a ‘day parent’ base.

As much as possible, children in special residence should be enabled to mingle with children of the community, and should go to school in the community – even if this means attendance of community special education programs. Too often, and without compelling reason, children’s residences have adopted the traditional residential school model, which contributes strongly not only to segregation but often also to the formation of a subculture milieu. Again too often, this subculture is not one that prepares the child for optimal adaptation to the main culture later in his life. The devastating effects of all kinds of segregation should be apparent to everyone by now.

Residential services for adults

The major invariant activity and mission of adults in our culture is work. This is likely to remain the case in the future, despite some predictions to the contrary. Therefore, adults in special residential management should be enabled to engage, as much as possible, in work that is adult in nature and connotation, is productive and remunerative, and adheres to a schedule that can be considered normative.

There is generally a good reason why an adult is under special residential management. Usually, the reason is some kind of impairment, in a broad sense. Thus, the work activities of residents should and must be graded along a continuum. Some residents will hold a full-time competitive job in the community, and the residence should provide only a minimum of needed support, shelter, and/or companionship. Other residents may work competitively in the community but only part-time, and receive other treatments the rest of the time. Yet others may work under sheltered rather than competitive conditions, full or part-time, and some may not work at all – hopefully only temporarily. However, it is fully to be expected that sufficient sheltered
workshops and other sheltered employment opportunities will be developed, beyond any extent most people can currently imagine.

Particularly in large population centers, sheltered living residences could be graded rather easily from those with minimal supervision to those with more intensive supervision. These gradations must be much more extensive than the frequently encountered institution/halfway house/independence trichotomy. An extreme type of minimal supervision might involve dispersed apartments in which residents live like ordinary apartment dwellers except for certain central services such as occasional walk-in supervision. In family-type residences, there would be much more intensive interaction between residents, and more socialization.

Some sheltered living units could be located so that residents would have access to training workshops, vocational training centers, and similar agencies. Thus, young adults would have an opportunity to attend such services to receive vocational preparation, and the atmosphere in this particular type of hostel could be structured so as to have a strong vocationally-centered emphasis. However, easy access does not mean adjacent locations, which often violates normalization principles.

In a normalizing program scheme, there is need not only for meaningful work, but also for recreation, each to be conducted at appropriate places and times. I doubt, however, whether there will be as much, or even any, use of occupational and recreational therapy as generally conceptualized and practised at present. Both of these ‘therapies’ are frequently dehumanizing: occupational therapy by substituting largely meaningless activity for meaningful work, and recreational therapy by substituting childlike play for adult work. In both cases, the client is engaged in activities which are only valued by society if they are performed in certain contexts. Persons performing these activities in un-normal contexts, at un-normal times, and in un-normal amounts, are doing things which are either not generally valued, or which may even be devalued, and consequently the persons so engaged are not valued either.

Residential services for the aged

Old age is a great leveller. Persons who once were disordered, retarded, or well-adjusted and highly contributive citizens all may be equally disabled in their old age, and require similar types of care.

Increasingly, there is sentiment (which happens to be consistent with normalization principles) that the aged person who was deviant in his younger days and who needs a special residential service in his old age should be integrated into homes for the aged which are located in or near his home community.

Great progress has been made in placing aged residents of our public mental institutions into nursing homes. However, considerable further progress is indicated. I suspect that a much larger number of institution residents could be placed into such homes, and that they could be placed closer to their home communities than in the past. However, a great deal of work remains to be done to assure adequate and humane programming in services for the aged throughout North America. At present, the situation is a national disgrace, and in many instances we have emptied large isolated human warehouses only to create small isolated ones. Above all, we need citizen advo-
cacy, integrative safeguards, and accountability systems, such as discussed in the last part of this book, in order to assure that normalization will be achieved for the aged as much as for other groups.

In the chapter on ‘Implications in the field of mental health’, more will be said about the normalizing effect of work upon adults. At this point, it will only be mentioned that many adults in special residence, by the very fact that their functioning has been reduced so as to require this type of service, are in financial straits. This presents a problem, since poverty in our culture can be destructive of one’s self-concept, demoralizing, and dehumanizing. This implies that managers should be very concerned with the owning and earning capacity and behavior of clients. As much as possible, clients should be provided with ownership, not only of their own possessions, but also of their life space in the residence. Furthermore, work generally should be provided not only as a normal adult activity, but in many cases also as a means of transmitting money to the residents. At the very least, the resident generally should have, and control in adult fashion, enough money (not scrip or credit!) to be able both to indulge his minor whims (refreshments, snacks, smokes, small gifts) as well as feel the satisfaction of earning. In Danish and Swedish human management services, clients who are impecunious or cannot earn money are provided generous allowances so as to increase dignity, assist in realistic social training, and foster independent choice behavior.

Considerations for all age groups

Residential services should be alert to measures which simultaneously are behavior-normalizing as well as image-normalizing. A normal rhythm of the day means that most people should not have to rise significantly earlier than typical fellow citizens, or have to go to bed at odd hours. It also means that they should be able to eat their meals at normal hours; few citizens eat their supper at 4:30 or 5:00 p.m., as do clients in many of our residential facilities. Not only can abnormal schedules foster abnormal habits, but they also can make a person appear odd.

Most people go on a vacation trip once a year, which breaks up the routine of life. Few things are as monotonous as long-term residence in a special facility. It is thus normalizing to provide annual trips for such residents to the usual tourist and vacation places. In Scandinavia, even the severely retarded are taken on vacation trips – often abroad. Although cost may be a problem, at least some arrangements can be made, even if it is only a trip of two to three days’ duration to a vacation home owned by the facility.

Normalization also dictates that a person should be as independent, free to move about, and empowered to make meaningful choices as are typical citizens of comparable age in the community. As much as possible, his wishes and desires should carry the same weight as they would in ordinary circumstances outside of a human management context. This means that unless it is essential, a person should not be submitted to a 'mortification' process upon attaining client status or 'patienthood' (e.g. stripped of clothes and possessions, locked up), and that generally he should not be prevented by even nonphysical (e.g. social and psychological) means from exercising normal freedom of movement. Furthermore, a person generally should have reasonable control over his physical environment, including freedom to turn lights on and off, to open and close windows, to regulate the temperature in
his room, and to decide whether he wants another person to enter or not. A nurse or other manager sweeping abruptly into a resident’s room commits an act of denormalization. No person should be deprived of his physical freedom or his freedom of choice because he is housed in a facility with other people who appear incapable of exercising these freedoms.

Residences serving a deviant group must meet at least the same standards as other comparable facilities for nondeviant persons. Imposition of either unnecessarily stringent or indefensibly lax standards would be equally inappropriate; and yet, this is exactly the present situation in North America: community hostels have irrationally stringent health, welfare, and fire regulations imposed upon them, while institutional housing conditions are permitted to descend to the snake-pit level.

It is conceivable that many individuals in various community residential services, especially those for children, will return to their families over the weekend. Thus, for many individuals, residence would consist mostly of five day a week residence. Particularly in areas of high population concentration, it will be possible to specialize residential hostels to such a degree that some units could be placed entirely on a five day a week basis, closing down over the weekend and thereby effecting considerable savings.

Normalization implications to individual placements

In the past, inability to continue normative community functioning independently or within one’s family was almost automatically equated with group placement. In most fields, group placement meant institutional placement; in some fields, especially mental retardation, it also meant life-long institutional residence. Often, the life-long total service of the institution was imposed as a solution to a short-term situational family crisis, and while it was difficult to gain admittance to an institution, it was often even more difficult to gain release from it.

Yet, there is an alternative not only to institutional but even to group placement that can not only have powerful normalizing features, but that is often also cheaper. And that is individual placement. Three major forms of individual placement suggest themselves: family boarding, foster, and adoptive placement.

Family boarding placements

The term ‘family boarding’ can have multiple meanings, some of them equivalent to fostering. I propose to use the term to refer to temporary individual (rather than group) placement of a child who has a home which continues to function as the primary and legal residence; and any individual placement of an adult into a family setting where he receives room and board, regardless of the likely duration of the arrangement. (Note that this definition excludes the typical community group boarding home.) In both cases, it is assumed that the family providing boarding receives remuneration, and it is obvious that family boarding can be for adults what fostering is for children. The term ‘family care’ is sometimes used to refer to both foster- and boarding-type arrangements.

Family boarding placements for impaired individuals, especially for adults, were common prior to the advent of institutions. During the alarmist period (circa 1890-1925), family boarding was ruled out by attitudes; be-
tween 1925 and the recent past, it was ruled out by ignorance and the lack of legal and fiscal frameworks. Today, it is ruled out only by rigidity in our service structures.

Yet, family boarding placement is a creative and very normalizing alternative to the hostel placement of an adult who is in vocational training or in sheltered or competitive work. In rural areas, it is of particular promise regardless of the boarder's age. For instance, in sparsely populated areas, certain services may not be feasible on the local level even in the service system of tomorrow. Day programs in clinics, special classes, workshops, etc. may have to be located in regional population centers which are beyond commuting distance of much of the surrounding population. One solution, of course, is the establishment of hostels, including some that operate only five days a week. Such hostels, for example, have been established in many communities in rural Nebraska, and serve severely retarded children who live with houseparents and who attend special public school classes during the day.

However, even more creative than five-day hostels is the provision of five-day boarding arrangements. Again, such boarding situations with individual families have been set up for retarded persons in numerous Nebraska towns. This arrangement has several advantages: a more individualized relationship; a more normalizing atmosphere; economy; reduction of the hostel staffing problem; and a solution to the problems of finding buildings that meet the stringent fire codes for group living.

Once the advantages of boarding arrangements have been recognized, and once resistance to novel service options has been overcome, this provision probably will play a role in reducing demand not only for institutional but also for other types of group residences, at least in some service areas, and especially for children.

**Foster and adoptive placements**

Foster and adoptive placements constitute additional types of individual residential placement. Again, such placements were often ruled out because of peculiar attitudes and practices that prevailed and largely still prevail in the relevant agencies. Such attitudes often demanded that prospective substitute parents be paragons of parenthood — better even than the typical parent in the community — motivated only by idealism and unmoved by material incentives. Thus, it came about that foster homes were ridiculously underpaid, and that numerous children were placed into no-love high-cost institutions rather than into medium-love medium-cost foster homes, even though a workable legal-fiscal and even administrative structure existed.

In addition, an almost universal agency dogma was that citizens would not accept a handicapped child for foster or adoptive placement. Today, we can only wonder to what degree this agency dogma was an agency myth. What we do know is that prophecies can be self-fulfilling. Obviously, an agency worker who 'knows' that handicapped children cannot be placed is not going to seek such placements and support them with vigor and inspiration, if at all; and he is therefore not likely to make many successful placements, if any. Franklin's (1969a, 1969b, 1969c) documentation of successful adoptive placements of children with even severe medical conditions is highly revealing.
In Omaha (Nebraska), the College of Medicine wanted to find foster homes for seven mongoloid infants who had been transferred from the institution to a ward at the College for a research project. With the agencies emitting the customary pessimism, a young nurse and a social work student were told to go out and do the job. These two people employed unorthodox means such as a mobilization of the news media, and within two months, every child had a foster home. Three years later, six children were still placed; had they been free for adoption, several would have been adopted by their foster parents.

In and near one small town in Nebraska, 36 retarded children live in foster homes. Many of these children are severely retarded, and would otherwise be in institutions. One middle class family fostered a profoundly retarded child who is almost deaf, not toilet-trained, and wears braces on both legs from hip to toe. The placement was mediated by a child-development teacher – not a child placement agency. Had the child been free for adoption, she would have been adopted by the foster parents. Similar reports of the feasibility of foster-placements are beginning to trickle in from other sources.

The realization is slowly growing that removing a handicapped or high-problem child from his home need not be tantamount to institutional or even group placement. Foster, adoptive, and family boarding placements are virtually unmined resources of potentially major proportion. However, to actualize these resources, it may be necessary to provide more vigorous programmatic, and more realistic financial, backup than has been customary in the past. Rearing a handicapped child can be very expensive. Thus, the fees for fostering a high-problem child should be increased substantially – at the same time as certain standards for foster homes are raised and others lowered. Adoption of such children – and perhaps other children as well – should be subsidized (e.g. Wheeler, 1969) to facilitate this powerful option. To both foster and adoptive parents, a continuum of services should be made available. Particularly, specific child development guidance and assistance should be offered in order to assist the parent surrogates in surmounting the crises of the family life cycle.

One day these things will be done, and not only institutions but even other group homes will be prevented from admitting any child that can be fostered or adopted. Such developments will not only reduce the demand for group residential places rather directly, but also indirectly: parents who now seek and obtain institutional placement inappropriately will refrain from seeking such placement if they know that another family, probably in the same town, will accept their child as their own.

Concluding statement on individual placement

Obviously, foster and adoptive placements are only normative for children – not for adults. Family boarding can be highly appropriate for adults under select conditions; they are more appropriate for young adults and the aged than for mature adults; and they are more appropriate for young adults in a five-day context in which they attend a program during the week while living with their families on weekends.
Manpower implications of small, dispersed services

A common objection to the dispersal of services is the claim that the professional manpower that is necessary to staff dispersed services cannot be found. This contention is probably partially true and partially false, and must be examined very carefully.

First of all, concentration of services is no guarantee for the solution of manpower problems. For various reasons – not all of these associated with the manpower shortage – agencies even in favored circumstances may have recruiting problems. Thus, dispersed services are not necessarily worse off than concentrated services.

Secondly, in many service fields, dispersal of services consistent with population patterns would actually bring about relocation of previously remote services into population centers, where some manpower problems can be solved more easily. Many large public institutions are located in small communities, and it has been most difficult to attract professional staff to such locations and institutions. In mental retardation, for instance, dispersal would mean the development of many smaller facilities, most of which would be located in cities where professional manpower is easier to obtain, concomitant with the phasing out – or at least the phasing down – of the large institutions.

Thirdly, the majority of residential facilities can be so specialized that they can be opened without a full range of professional disciplines in constant attendance, and those professionals required on the spot could be of lower and intermediate levels of training. In some cases, such as certain sheltered-living hostels, professional personnel is only required on a back-up basis. Fortunately, personnel of intermediate levels of professional training can often be found even in small cities, especially if use is made of married women with appropriate training, and if such women are permitted part-time work (see Cooke, 1969, for relevant analogies in the area of nursing homes).

From the above analysis, it appears that dispersal of residential units, and their specialization around disciplinary rather than multi-disciplinary models, should actually contribute to the easing of the manpower problem.

A system of dispersed and specialized residences works best if it is supported by an adequate back-up system. Such a system would appear to have two major components: a pyramidal continuum of residential options, and a manpower back-up. The pyramidal residential continuum implies that a resident in a more common service that usually requires little specialized manpower can always move back to a more specialized, professionalized, and less common one.

The manpower back-up might be provided out of administrative regional headquarters, and might include the following:

consultants to residential personnel;

counsellors who go to the hostels and other residences to counsel residents on a variety of problems;

recreation specialists who encourage, arrange, or provide recreational activities, mostly for evenings and weekends;
houseparent assistants who can be assigned from day to day to resi-
dences where a sudden manpower shortage or need arises;
roving janitorial services.

Conclusion
I can see no reason why small, specialized living units (mostly hostels) cannot accommodate almost all of the persons now in institutions. In turn, I believe that many persons who could be well served in hostels will be served even better in individual placements. Thus, we should bring about not only movement from institutions to other group residences, but also a decline in the demand for any type of group residence.

Furthermore, any feature of a residential service that is normalizing will increase the likelihood that the resident will either return to his family, move to a more advanced form of residence (e.g. from hostel to boarding), or be fully habilitated. Therefore, the more normalizing atmosphere and practices of small group residences, the use of community instead of segregated resources, the maintenance of family ties because of close physical proximity, the use of five-day instead of seven-day, and nine-month instead of twelve-month residences, all of these should combine so as to reduce the need for life-long residence, and increase the movement from group to individual residence.

In addition, the open-endedness in the flow into and out of the various types of residences, and the increased availability of residential services specifically geared to genuine short-term crisis relief (e.g. 'vacation homes', or 'crisis assistance units' as proposed and described in Governor's Citizens' Study Committee, 1968b) are apt to further reduce the need for long-term or even life-long residences. In sum, there are many features associated with a normalized residential model which will tend to diminish the need for residential places of any kind, while simultaneously being very economical.