The development of a residential program prototype for mentally retarded individuals in Franklin/Hampshire counties.

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THE DEVELOPMENT OF A RESIDENTIAL PROGRAM PROTOTYPE
FOR MENTALLY RETARDED INDIVIDUALS IN
FRANKLIN/HAMPShIRE COUNTIES

A Dissertation Presented
By
HAROLD MITCHELL HUTCHINGS

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION
September 1980

School of Education
Harold Mitchell Hutchings 1980

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THE DEVELOPMENT OF A RESIDENTIAL PROGRAM PROTOTYPE FOR MENTALLY RETARDED INDIVIDUALS IN FRANKLIN/HAMPShIRE COUNTIES

A Dissertation Presented
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Dedicated to my parents

Elmo Corbett Hutchings
and
Margie Mitchell Hutchings

and to

my wife,
Jane Theresa Miller
ACKNOWLEDGEMENTS

To Dr. Atron Gentry, chairperson of my dissertation committee, my thanks and appreciation for his support and guidance. Sincere appreciation is also extended to Dr. Arthur Pappas for his willingness to fight against the odds of the bureaucracy and direct my energies to the task at hand, and to Dr. Penny Rhodes, whose concern and understanding saved this entire process. Many thanks are accorded to Dr. Roger Frant, whose questions, directions, assistance and friendship made this possible.

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ABSTRACT

The Development of a Residential Program Prototype for Mentally Retarded Individuals in Franklin/Hampshire Counties

(September 1980)

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The purpose of this study was to develop a residential living/learning prototype for formerly institutionalized mentally retarded individuals. This study utilized present Massachusetts Department of Mental Health models, literature and a field survey as a data source. The prototype addresses the concerns expressed by:

1) Administrators of residential programs for mentally retarded individuals in Franklin/Hampshire Counties - those individuals having responsibility for residential program/budget development, program policy, staff selection, supervision and evaluation.

2) Direct care staff - those individuals assigned to residential programs having responsibility for direct training and/or supervision of the mentally retarded residing there.

3) Concerned citizens - members of the community who are not parents of a mentally retarded individual.
4) Parents/guardians of mentally retarded individuals.

A Likert multiple response survey instrument was developed to survey the mental retardation residential attitudes of these four groups.

Data for the study was collected by having each group respond to the survey. If needed, group and individual meetings were held to address concerns regarding the completion of the survey. The Franklin County Association for Retarded Citizens and the Hampshire County Association for Retarded Citizens provided the parent/guardian nucleus responding to the survey. Members of the association not parents/guardians were surveyed as concerned citizens. The Franklin/Hampshire Area Board, the citizen body which makes program and budget recommendations to the Massachusetts Department of Mental Health Franklin/Hampshire Area Office, served as the nucleus of concerned citizens. The three major mental retardation residential service providers in the Franklin/Hampshire Counties provided the nucleus of administrators and direct care staff responding to the survey.

Comparing the responses of these four groups provided valuable information around which a residential prototype was developed. This prototype capitalizes on areas of agreement and addresses areas of major concerns.

An analysis of the results of the study indicates that the major concerns raised by the four groups responding were related to resident supervision, and resident and staff
training. These concerns are representative of the overall desire on the part of all involved to provide quality residential services embracing the concept of normalization.

At the close of the study, a program prototype, broken out in basic skill proficiency levels, is presented as a guide for developing residential training. This prototype addresses the concerns identified in the analysis of the results of the study.
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CHAPTER I
INTRODUCTION

This dissertation is concerned with the development of a residential living/learning prototype for formerly institutionalized mentally retarded individuals utilizing present Department of Mental Health models, literature and a field survey as a data source. For the purpose of this dissertation "formerly institutionalized mentally retarded individuals" will encompass individuals exhibiting developmental characteristics relative to the mild, moderate and severe categories as outlined in Samuel A. Kirk's *Educating Exceptional Children* (Appendix A).

A basic assumption of this study is that parents, direct care staff, administrators and citizens can contribute in a critical way to improve the quality and community acceptance of residential programming for mentally retarded individuals.

The attitudes of administrators, direct care staff, citizens and parents of retarded individuals reflect and contribute to the type and quality of services planned for and found in the community. Surveying and comparing the attitudes of these groups provided valuable information to assist with the development of a residential prototype addressing major concerns and capitalizing on areas of agreement.
Present Models/System

Several types of community residences have evolved in recent years. Generally they fall within four major categories.

1) Group residence - has no requirement that the residents leave for total independent living within a specified time interval. There is little, if any, educational programmatic structure. The staff supervises and maintains order with limited planned community exposure. The majority of the day to day duties, in cooking, cleaning, washing, etc., is the responsibility of the residential staff.

2) Halfway house - explicitly expects residents to leave for independent living within a defined time period. The residential staff is involved with educational/training programs within the residence. Exposure to community activities is a key to the educational programs developed. The residents, with staff guidance, assume the responsibility for day to day residential duties.

3) Cooperative apartment - a group living arrangement which may become a person's permanent residence, or it may be transitional. No staff live in the apartment, however, daily supervision is provided and a mechanism, plan, etc., is in place to contact staff if assistance is needed.

4) Foster family - provides room and board for one to three individuals who need an alternative home. The home
may provide a permanent or transitional living arrangement.

The Massachusetts Department of Mental Health is the State agency having responsibility for providing services to institutionalized mentally retarded individuals. Residential community services for the retarded are provided through community agencies who contract with the Department of Mental Health to provide these services.

There are various organizational auspices possible for the operation and administration of community residences. These include private proprietary or nonprofit agencies, State government agencies, and joint private/State agencies. Operating a nonprofit charitable corporation facilitates the receipt of public funds and foundation grants as well as private contributions. Profit-making corporations can receive State funds through contracts when funds are available for services rendered at a rate compatible with those determined by the Rate Setting Commission. If a program is operated directly under public auspices, funds may be readily available through the agency's operating budget, or staff may be re-allocated from other State programs. By investing programmatic and fiscal responsibilities in non-State organizations while using State funded staff and ancillary supports, maximum flexibility is possible. (Task Force on Mental Health Planning, Massachusetts Department of Mental Health, 1975).

The contract/service is monitored by the Department of Mental Health with the community agency assuming responsibility for delivery of service.

Within Franklin/Hampshire County (Appendix B), there are four major mental retardation residential service contractors serving some 100 plus mentally retarded individuals. Greenfield, Massachusetts, a city of approximately 19,047 serves as the residential center for Franklin County.
Northampton, Massachusetts, a city of approximately 30,141 serves as the residential center for Hampshire County.

Three of the residential service contractors provide services in Hampshire County and one service contractor provides residential services in Franklin County. All provide a combination of group, halfway, and cooperative apartment residential service. Currently none are providing foster family services.

Concerns

Many parents and guardians of institutionalized retarded individuals have misgivings regarding community training and placement. They feel that while the community offers more opportunities for success, the possibility of abuse is increased.

Most parents believe their children/adults are happier in a familiar place among friends; and some do not trust the community where the retarded person seems an easy mark for those who use and abuse the weak. (Orientation Manual on Mental Retardation, page 34).

Attempts to deal with the misgivings of community placement has led to the development of residential programs which are largely self-contained. These residential programs are often managed by young couples, one being a full-time employee of the program, the other working outside the house each day or attending school and working as a part-time employee in the evenings. (Task Force on Community Mental Health Program Components, 1975). It is the responsibility
of this couple to provide the necessary training, skill development and monitoring enabling the mentally retarded residents to function in a manner acceptable to the community. The implied security, protection and monitoring of a small group of people and the home-like atmosphere of this type of program help ease parent and/or citizen fears of community placement. This program model is suitable for high functioning mentally retarded individuals requiring minimal supervision, training and guidance.

The movement of lower functioning mentally retarded individuals from the institution to the community has again raised misgivings and reluctance regarding their placement and training. Schearnberger's (1975) survey of 139 public residential facilities throughout the United States reveals that approximately 70% of the population remaining in institutions fall into the severely/profoundly retarded category. Adequate supervision, comprehensive support services, experience and training of direct care staff, appropriate leisure time activities, and community acceptance are but a few of the concerns raised by parents/guardians. The community, on the other hand, appears concerned about the lower functioning retarded not having acquired the functional and basic social skills needed to survive in the community. They do not wish to assume the responsibility, financial or otherwise, for the inherited risks, discomfort, and failures which might occur from an institution to community move.
Living/Learning Programs

In order to effectively address the concerns raised by parents/guardians and community plus increase the mentally retarded's possibility of success, residential programs should view themselves as programs, in addition to residences. Community residences should operate programs providing residential services for a variety of disability groupings. (Task Force on Community Mental Health Planning, Massachusetts Department of Mental Health, 1975).

The structure of the program should be one which seeks to develop and improve specific skills areas within the framework of the total person. Such a program structure can be compared with that of our school. Example: When a child enters school, the teacher seeks to develop skills that can be built upon. He/she does not attempt to provide the total educational experience. He/she sharpens the skills and behaviors which will enable those experiences to be understood and enjoyed. The expectations, job description, performance goals, etc. of the teacher are made clear (reinforced by classroom praise, report cards, meeting with parents and promotion).

The teacher by promoting the study, signifies that he/she has reached the goals of that grade and is ready to learn the skills associated with the goals of the next grade.

We must begin to view community residences not only as alternative living sites but also as alternative learning
sites for the retarded. This programming view is supported in a recent study by Marsha and Gary Seltzer (1978). In forming their recommendations for community programs they state:

we furthermore recommend that group homes be heavily educational in orientation in order to equip clients with the requisite skills for community living. Therefore, staff with a special education background should be part of the staffing pattern (Seltzer & Seltzer 1978, p. 166).

These living and learning sites must be programs developed jointly by staff, parents, administrators, and community geared to meet the needs of the residents. Hence, the residential programs need not reflect the house parent model previously mentioned.

This study describes what administrators, parents, direct care staff and the community feel are the necessary components of a residential living/learning prototype.

Many parents are concerned with the quality of care and training provided in residential settings. Frequently the difference in "parental quality" and "residential quality" leads to frustrations and misunderstandings on the part of administrators of residential programs, direct care staff working with the residents, parents of the residents and the residents themselves. This fragmentation often results in the community developing a negative pre-conception regarding the ability of those connected with the residence.

Braginsky and Braginsky, 1974 and the Residential
Services Community Housing Options for Handicapped People (1975), indicate that one of the major problems facing community residential programs is parent/guardian and community support. This study outlines the basic program components and characteristics necessary to address the concerns and thereby gain the support of these two groups. In addition, the information collected from program administrators and direct care staff provides a balance between the "wants" of those outside of the program and the "needs" of those inside the program.

It is important to understand that any program prototype developed must be adjusted dependent upon the needs of the individual(s) to be served. Maloney and Ward (1979, p. 306) make reference to this in the following quote:

"Although we must always strive to achieve the goals of normalcy, we cannot ignore the fact that some people have limitations which preclude their behaving in a normal fashion and living in a normal environment."

Survey of Attitudes

It is the feeling of the author that the attitudes of administrators, direct care staff, citizens and parents of retarded individuals reflect and contribute to the type and quality of services planned for and found in the community. Surveying and comparing the attitudes of these groups provided valuable information to assist with the development of a residential prototype addressing major concerns and capitalizing on areas of agreement.
CHAPTER II
REVIEW OF LITERATURE

This chapter reviews the pertinent literature tracing the development of institutional residential models as they relate to community residential programs.

Introduction

Society's changing attitude toward the retarded is documented in the institutions and institutional models developed to shape their destiny. The original residential institutions for the mentally retarded developed from the vision of education and preparation for the goal of self-sufficient life in the community. This evolution, beginning the early 1900's, went through a period of goal reversal, with separation of the retarded person eventually becoming a goal in itself. As a result of this reversal, institutions for the mentally retarded proliferated at an unprecedented rate during the first half of the twentieth century. Beginning in the early 1960's, the goals of residential services for the retarded began to resemble the goals of the founders--reintegration into the community in as normal a manner as possible.

The following review of the literature will explore the institution and its models as they relate to the attitudes which served as the impetus of their development.
Institution as a School

In 1848, the first State school for the mentally retarded was founded in Massachusetts. Upon the urging of Dr. Samuel Gridley Howe, the Massachusetts legislature had authorized a commission two years earlier to study the status of the feeble-minded in the Commonwealth. Dr. Howe was firmly convinced of the educability of the retarded population. A pioneer in the field of retardation, he had studied with Edward Seguin in Europe and attempted to bring his theories back to the United States. Seguin had been a student of Itard, the physician who conducted a long term educational experiment with an uneducated, handicapped young man who had been raised in the forest of Aveyron without benefit of human interaction. Although Dr. Itard did not consider his experiment with the 'wild boy of Aveyron' to have been successful, it is regarded as a critical incident in the origins of professional attention to the education of the handicapped. Gradual improvements in the boy's behavior were regarded as evidence in the educability of the retarded. Itard's pupil, Edward Seguin, was later to emigrate to America and continue his work in the field in collaboration with Dr. Samuel Gridley Howe (Dunne, 1964).

In establishing the Massachusetts School for Idiotic Children and Youth, in 1946, Dr. Howe insisted that it be "... organized upon the plan of a family with a kind and
mother person in care . . .;" that its sole concern be with education during the "best learning years" and they be "returned to their families (President's Committee on Mental Retardation, p. 4)." Other institutions established during this period also embraced this philosophy. They viewed themselves as experimental boarding schools "... a link in the chain of common schools--the last indeed, but still one necessary in order to make the chain embrace all the children . . . (Howe in Wolfensberg, p. 25)." These experimental schools, as described by Rosen, Clark and Kivitz, chose "a few 'idiotic' children as subjects to demonstrate the effectiveness of particular training procedures on a small scale (Rosen, Clark, Kivitz, p. 103)."

As a result of Dr. Howe's and Edward Seguin's influence, the goal of the first residential institution was to provide education and training of a nature that the retarded person would return to the community in as self-sufficient a manner as possible. Dr. Howe's methods, modified from his experience in teaching the deaf and blind, incorporated a variety of experiential learning geared toward competency in daily living skills. Edward Seguins' work in France had had the same emphasis. A variety of sensory modes were used to teach the students, based upon recognition of the lack of relevance of the traditional curriculum and manner of teaching to the mentally retarded population.
Change in Focus

At the outset, Howe and his followers had promised the training of residents of the institutions for capable return to society. The implication was of a brief treatment at the institution and a return to society cured of the defects that had identified the person as deviant (Wolfensberger, 1975). Many residents were much improved under the tight and well planned training regimens of the institutional experimental school and a substantial proportion of trainees were returned to the community. Seguin, after thirty years experience, was reported to have said:

Idiots have been improved, educated, and even cured. Not one in a thousand has been entirely refractory to treatment, not one in a hundred who has not been made more happy and healthy. More than 30 percent have been taught to conform to moral and social laws, and rendered capable of order, of good feeling, and of working like the third of a man. More than 40 percent have become capable of the ordinary transactions of life under friendly control, of understanding moral and social abstractions, or working like two-thirds of a man; and 25 to 30 percent have come nearer and nearer the standard of manhood till some of them will defy the scrutiny of good judges when compared with ordinary young men and women (Seguin, as quoted by Carson, 1898, pp. 294-495, in Wolfensberger, 1975, p. 25).

However, many people misunderstood the objectives of the institution founders and expected complete and rapid cures in large numbers. Accomplishments of a lesser degree were interpreted as failure. With the perceived failure of the institution as a school, community ideologies changed from developing educationally focused programs to providing
facilities of protection and custodial care (Wolfensberger, 1975, p. 28). This era of protection of the mentally retarded led to the proliferation of institutions responding to the unwillingness of communities to integrate them into the mainstream. The establishment of public institutions of this nature opened the floodgates for society to rid itself of undesirable individuals. In an 1866 speech at the Batavia New York State Institution for the Blind, Dr. Howe questioned whether this enterprise might not be a mistake:

... Society, moved by pity for some special form of suffering, hastens to build up establishments which sometimes increase the very evil which it wished to lessen ... Our people have rather a passion for public institutions and when their attention is attracted to any suffering class, they make haste to organize one for its benefit ... All great establishments in the nature of boarding schools, where the sexes must be separated; where there must be boarding in common, and sleeping in congregate dormitories; where there must be routine and formality, and restraint and repression of individuality, where the chores and refining influences of the true family relation cannot be had, all such institutions are unnatural, undesirable and very liable to abuse. We should have as few of them as possible, and those few should be kept as small as possible. The human family is the unit of society (President's Committee on Mental Retardation, 1977, p. 5).

As public institutions opened across the United States, they were quickly filled with individuals who were deprived of community acceptance. Institutions became society's acceptable haven for devalued individuals. The population became a mixed bag of deviants with varying abilities to learn independent behavior.
Institutions as Custodial Facilities

Dr. Howe's death in 1876 marked the end of the experimental institutional school era. His successor, Dr. I. N. Kerlin, disagreed with Howe's principle of preparing the mentally retarded for return to the community. Dr. Kerlin felt that the retarded were aliens in their own homes, foreign to community rules and habits and viewed as children (I. N. Kerlin, Annual Report, PA School for Feeble-minded, 1875, pp. 17-18 in President's Committee on Mental Retardation Report, 1977, p. 6). He linked the retarded existence to poverty, crime, insanity, prostitution, alcoholism, and immorality in general. Wolfensberger, 1975, states that retarded adult males were characterized in the Maine Senate as "town loafers and incapables," "petty thieves," "incendiaries," sources of "unspeakable debauchery" which "pollute the whole life of young boys" and who have "illegitimate children everyone of whom is predestined to be defective mentally, criminal or an outcast of some sort (p. 41)."

Kerlin, and other institutional founders of this period, began to transform the institution from schools to custodial facilities. Hence, admission to an institution training school became the first step to permanent care. Instead of educationally focused programs to assist the less able members of society, the institutions became protectors of the larger society by separating the deviant from them. Wolfensberger (1972, p. 123), attributes the reversal in goals for
institutions for the mentally retarded to "the dissipation of dynamism during the so-called genetic alarm period (circa 1890-1920) when it was thought that the mentally retarded person was the mother of social ills and could destroy our society." Hence, the institutions for the retarded became more like penal institutions as their perceptions of their functions shifted from benevolence to isolation.

**Alarmist Period**

During the first two decades of the twentieth century, several sets of circumstances led to what might be called an "alarmist" period in the care and treatment of the mentally retarded. Dr. Alfred Binet and Dr. Theodore Simon's development of scales for the measurement of intelligence led to widespread testing and called attention to the relatively large number of retarded children in the population. The emerging science of genetics defined by Sir Frances Galton as "the science which deals with all influences that improve the inborn qualities of a race (Wolfensberger, 1977, p. 10)," indicated that the subnormal tend almost invariably to reproduce and multiply their kind in ever growing numbers.

Studies and writings by Richard Dugdale, the best known of which was his book, The Jukes: A Study in Crime, Pauperism, Disease and Heredity (1910), claimed proof beyond a doubt that mental retardation was a problem of bad blood passed on from generation to generation. Henry Goddard, a sociologist,
produced a widely read book in 1912 entitled The Kallikak Family. This book supported Dugdale's bad-blood theory by tracing the descendants of Martin Kallikak, Sr., and the mothers of his children, one considered feeble-minded and one who was normal.

Perhaps the attitude of this period is best summarized by Dr. Walter E. Fernald.

During the last decade four factors have materially changed the professional and popular conceptions of the problem of the feeble-minded:

(1) The widespread use of mental test has greatly simplified the preliminary recognition of ordinary cases of mental defect and done much to popularize the knowledge and extent and importance of feeble-mindedness.

(2) Intensive studies of family histories of large numbers of feeble-minded . . . have demonstrated what hitherto only had been suspected, that the great majority of these persons are feeble-minded from generation to generation in accordance with the laws of heredity . . .

(3) The cumulative evidence furnished by surveys, community studies and intensive group inquiries have now definitely proved that feeble-mindedness is an important factor in the cause of juvenile vice and delinquency, adult crime, sexual immorality, and the spread of venereal disease, prostitution, illegitimacy, vagrancy, pauperism, and other forms of social evil and social disease.

(4) Our estimates of the extent and prevalence of feeble-mindedness have greatly increased by the application of mental test, the public school classes for defectives, and the interpretation of the above mentioned antisocial expression of feeble-mindedness and the intensive community studies. It is conservative to say that there are at least four feeble-minded persons to each thousand of the general population (Wolfensberger, 1977, pp. 10-11).
Coupled with these findings and societal attitudes was the sweeping generalization widely accepted on limited and incomplete evidence and frequently broadcast by writers on population questions that the retarded reproduced at a much more rapid rate than normal stocks. It was believed that this differential birth rate would threaten to overwhelm civilization (Davis, 1968; Wolfensberger, 1977; Penny, 1966). This concern over the possible spread of mental defectiveness through inheritance was responsible for the advocation of segregation and sterilization. The use of congregate segregation in institutions had already become well established. The shift from educationally focused programs to custodial care provided a strong foundation for a program of control. Hence, segregation coupled with involuntary sterilization of retarded individuals promised to control if not rid society of this devalued population. Wolfensberger (1975) notes that it was soon recognized that sterilization, in order to reduce the number of the retarded to an appreciable extent, had to be compulsory, and such laws were passed throughout the nation and generally upheld by the courts.

Eugenic sterilization was adopted by a number of states in rapid succession. Indiana was the first state to enact a sterilization law (March 9, 1907). Washington, California and Connecticut enacted similar statutes in 1909 followed by New Jersey and Iowa in 1911 and New York and Nevada in 1912. By 1926 twenty-three states had enacted such laws (Davies,
Sterilization laws did not produce the control nor reduction of retardation to the degree anticipated. Many institutions moved to advance the ideology of segregation. "Not only were the retarded to be segregated from society, but even within institutions, men and women were strictly segregated almost to a paranoid and bizarre degree (Wolfensberger, 1975, p. 43)." The rebirth of the separation/segregation movement for the mentally retarded led to the need for many institutions to improve and enlarge in order to house societies unwanted. Economization was the lock on institutional segregation and increasing the institutional population to decrease the per capita cost was thought to be the key.

**Colonies**

During this period of separation/segregation of the retarded from the mainstream of society, there were some who felt that it was inhumane as well as uneconomical to confine in an institution at considerable public expense many strong, able-bodied persons who had never committed any serious offense (Davies, 1968). It was thought that it might be more economical and beneficial to both society and institutional residents to place groups of residents from the institution proper in normal living and working environments. The residents would remain under the necessary supervision of the
institution and needed beds in the institution would be released for more urgent cases. This particular train of thought gave birth to the institutional colony system. The colony system in essence was institutions that specialized in making the less retarded residents as self-supporting as possible by having them farm large tracts of land. The belief developed that with enough land, an institution could actually become self-supporting. A rule of thumb used to determine the acreage needed was one acre of land for each resident (Fish, 1892; Powell, 1887; Sprattling, 1903; Wallace, 1925). The following description of the State School named after Dr. Walter E. Fernald, the man primarily responsible for articulation of the colony model, illustrates the concept of such a model.

There, on several square miles of farm acreage, retarded people lived, worked, and supported the institution to a large degree, producing not only all the food required, but also fabricating in shops the clothing, furniture, and other furnishings needed for the institution (Fernald, 1919 in President's Committee on Mental Retardation, 1976, p. 13).

Dr. Martin W. Barr, author of the first American textbook on mental retardation (1904), proposed the ultimate institutional colony in his article "The Imperative Call of Our Present to Our Future" in the 1902 Journal of Psycho-Asthenics:

... The States may not be ready to respond to calls for many colonies, nor the institutions yet ready to supply them, but the national government might heed a proposition from us for one which would serve as an outlet for all.
An ideal spot might be found—either on one of the newly acquired islands, the unoccupied lands of the Atlantic seaboard, or the far West, which under proper regulations could be made a true haven of irresponsibility, and deriving its population as it would from the trained workers from the institutions throughout the country, might become in time almost if not entirely self-sustaining (Rosen, Clark, Kivitz, 1976, p. 104).

The colony system was viewed as the mechanism by which institutions could support the expensive custodial model and provide meaningful training and employment for those residents capable of working for the benefit of the institution. The model initiated by Fernald was to be followed by many States.

By the early 1900's the colony system had come to be regarded as a vital step in training for social living. It was used as a training center for community life and became the midway station between the institution and the community. Those that could work in the community were paroled to individuals or companies. The men were usually paroled to farm or industrial labor, while the women were paroled to domestic labor. Those unable to make parole remained on the "Happy farm."

Family Care System

The retarded's successful infiltration into the community's work force gave rebirth to the family care system.

The family care system, first introduced in Massachusetts in the late 1800's, and thwarted by the institutional
growth of that period, was a means of supporting a retarded individual in a home not his own through State or private funds. This system matched the cream of the institutional population with families willing to serve as their caretakers. The following description of the institution and family care system relationship illustrates the concept of the model.

The caretaker has the advantage of a dependable, though small income . . . Most patients are placed in country homes which have rooms not being used at the time. The institution virtually rents such rooms for patients, who also provide at the home table a market for produce raised on the farm. Many families welcome too, the companionship and the rewarding occupation of helping the patient (Davies, 1968, p. 143).

Many retarded individuals benefited greatly from the involvement in the family care model. They were no longer cut off from normal activities and the opportunities and stimulation of the community. Their success undoubtedly paved the way for a reassessment and change of societal attitudes regarding institutional care.

**Institutional Improvement**

The move for better institutional services and community placement began in the 1950's and 60's. Institutional warehousing of individuals was condemned and programs geared to develop basic skills and prepare the retarded for community living were initiated. In 1962, a special panel on mental retardation appointed by President Kennedy, made
the following principal recommendations regarding institutional care:

Institutional care should be restricted to those whose specific needs can be best met by this type of service.

Further institutions should:

- be basically therapeutic in characters and emphasis, and closely linked to appropriate medical, educational and welfare programs of the community;

- have some unique quality or potential that can be developed for the benefit of the entire field—and not merely custodial;

- provide diagnosis and evaluation before admission, followed by prompt treatment;

- develop institutional outreach to assist both patient and family before admissions and to facilitate visits after admission;

- provide flexible admission, release and outpatient policies;

- eliminate or ameliorate as many symptoms as possible in order to achieve independent, semi-independent or sheltered extramural life in accordance with potential;

- provide regular and frequent evaluation so that no child or adult will remain in residential care longer than necessary;

- insure that if and when the child or adult is ready to return to the community, adequate supportive resources and services will be available, including a variety of community residential option;

- provide continuity of service responsibility in transfer from institution to community;

(Page 116, President's Committee on Mental Retardation, 1976).

By the mid-1960's, an overt national policy on mental

Deinstitutionalization

The increased involvement of parents and advocacy groups in behalf of retarded citizens together with several landmark judicial decisions gave momentum to the deinstitutionalization movement. In 1954, the Supreme Court, in the Brown vs. Board of Education of Topeka, required the desegregation of Public Schools. This case overturned the "separate but equal" educational policy in effect since 1896 and set the stage for a series of actions brought in behalf of mentally retarded persons in the 1970's.

In 1972, a landmark case, Pennsylvania Association for Retarded Children vs. Commonwealth of Pennsylvania, inspired a large number of class action suits which subsequently led Congress to pass a law requiring all states to develop plans for providing public education to every handicapped child
regardless of degree of defect (P. L. 93-380, Education Amendment of 1974). In that same year, the Federal District Court, in Wyatt vs. Stickney, ruled that retarded individuals have the right to developmental and ameliorative treatment in least restrictive environment. Another case in 1972, Jackson vs. Indiana, saw the United States Supreme Court rule that it was a denial of equal protection and due process to confine a handicapped person indefinitely until he became competent.

In 1973 the District Court of the District of Columbia, in Sounder vs. Brennan, established the right to be free from institutional peonage and involuntary servitude. In that same year, in Urban League vs. Washington Metropolitan Area Transit Authority, the District Court of the District of Columbia enforced the right of free access to buildings and transportation systems for retarded and handicapped individuals.

In 1974 the Supreme Court decision of 1927 which affirmed involuntary sterilization for eugenic reasons was reversed in Wyatt vs. Aderholt. This decision upheld the right of the retarded to procreate and declared compulsory sterilization laws unconstitutional (President's Committee on Mental Retardation, 1977).

The President's Committee on Mental Retardation states that:

Recent developments in the courts upholding the
rights of the handicapped to educational opportunity have been followed by federal legislation (P. L. 93-380, Education Amendments of 1974, title VI B, and P. L. 94-142, Education for all Handicapped Children Act of 1975) underscoring the responsibility of the States to protect the educational rights of handicapped not now being served . . . (p. 238).

Normalization

Perhaps the most important development of the late 1960's and early 1970's was the articulation of the normalization principle. This principle was developed in the late 1960's by Benjt Nirje, former Secretary General of the Swedish National Parents' Association for Retarded Children. According to Nirje, the normalization principle is based upon "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of everyday society (Nirje, 1969)."

This philosophy, according to Seltzer and Seltzer, grew out of many historical trends:

. . . the social-action climate of the 1960's, the community mental health movement, Goffman's (1961) observations in total institutions, and the experiences of several of the Scandinavian countries in changing the locus of services from the institution to the community.

Wolf Wolfensberger (1972) expanded on Nirje's formulation and together with Gunnar Dybwad and Burton Blatt led the normalization movement in the United States. Wolfensberger defined normalization as "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are
as culturally normative as possible (Wolfensberger, 1972, p. 28)." He extended the normalization principle to specify "maximal feasible integration of deviant people into the cultural mainstream (p. 209)" as its major corollary. Normalization became to the field of mental retardation what equality of educational opportunity was to the civil rights movements of the fifties and sixties. It was the direct response to the inadequacy of our society in caring for its persons perceived as different (Towney, 1977).

The normalization principle was based on the notion that it is normal for people to live, learn, work and play in a variety of settings, and that institutions interfered with this typical flow of the day. Institutions were viewed as essentially not normal environments and, therefore, inappropriate as models of service. Normalization questioned the validity of the belief that the retarded should be separated from society in order to receive training preparing them to return to society. It further questioned the assumption of necessary specialized services for the mentally retarded, preferring to rely on generic services that were not of such segregated nature. Inherent in the normalization principle was the belief that "behavioral deviancy can be reduced by minimizing the degree to which persons are treated differently (Wolfensberger, 1972, p. 143)."

A movement developed that sought to provide community alternatives to institutions. This movement centered on the
development of small community residences and by 1973 there were over four hundred self-designated community residences for retarded adults in the United States (Baker, Seltzer & Seltzer, 1977). This large-scale movement of retarded individuals from institutions to community residential settings is one indication of the impact and importance of the normalization principle.

The normalization principle is responsible for a change of attitude on the part of professions in the field of retardation. The new optimism and energy is bringing about significant changes in the lives of thousands of retarded individuals. At no other time in the recent history of mental retardation has the field seen such a hopeful situation with a clear vision of a better future to come.
CHAPTER III
EVALUATION METHODOLOGY

The Sample

The data for this study was drawn from four major groups having responsibility for or interest in providing residential services for the mentally retarded in Franklin and Hampshire Counties. The four groups surveyed were:

1) Parents/Guardians of Mentally Retarded Individuals. This group is defined as those individuals who are natural parents of a retarded individual or who have through court action, been appointed legal guardianship.

2) Concerned Citizens. This group is defined as citizens of the community who are not parents/guardians of a mentally retarded individual and who are members of either the Franklin or Hampshire Association for Retarded Citizens or the Franklin/Hampshire Area Board. This area board is the citizens body which makes program and budget recommendations to the Massachusetts Department of Mental Health Area Office.

3) Administrators of Mental Retardation Residential Programs in Franklin/Hampshire Counties. This group is defined as those individuals having responsibility for residential program/budget development, program policy, staff selection, supervision and evaluation.

4) Direct Care Staff of Residential Programs for Mentally Retarded Individuals in Franklin/Hampshire Counties.
This group is defined as those individuals having responsibility for direct training and/or supervision of the mentally retarded residing there.

The purpose of collecting information from these four major groups was to develop a residential living/learning prototype for formerly institutionalized mentally retarded individuals.

**Evaluation Design and Rationale**

A Likert multiple response survey instrument was developed and used to survey the (mental retardation residential) attitude of Franklin/Hampshire administrators of residential services, direct care staff employed in these residences, citizens and parents of mentally retarded individuals. The term attitude as defined by Daves (1972) and applied to this study is:

... the predisposition of the individual to evaluate some symbol or object or aspect of his world in a favorable or unfavorable manner ... attitudes include the affective, or feeling core of liking or disliking, and the cognitive, or belief, elements which describe the effect of the attitude, its characteristics, and its relations to other objects.

The author's choice of the Likert survey method was based on the following points outlined by Gary M. Maranell (1974):

1) Likert Scaling is one of the simplest and easiest methods to use.

2) Simplicity of item wording:

   The process is often referred to as 'farmerization'
--i.e. making item intelligible to the less sophisticated.

3) Reliability:
Likert's technique appears slightly preferable, both because scores are easier to compute and because it has shown by Likert, Roslow and Murphy (1934) to produce rather higher coefficients of reliability.

**Survey Questions**

The questions used in the survey were developed from program monitoring concerns raised by the Franklin/Hampshire Area Office mental retardation staff and the citizen monitoring team of the Mental Retardation Subcommittee of the Franklin/Hampshire Area Board. Based on a review of the Franklin/Hampshire Area Office and citizen monitoring reports covering the period of 1978-1979, it was found that the areas of concern could be grouped into five categories. Those categories were:

1) Concerns related to insufficient Department of Mental Health program funding.

2) Concerns related to program staff qualification and/or training.

3) Concerns related to program size.

4) Concerns related to program location.

5) Concerns related to program responsibility.

While the need for additional funding is justified, the political and societal atmosphere of this period is one of fiscal restraint. With this in mind it became apparent that by addressing concerns 2-5 and improving program quality and
support, a rational appeal for additional funds can be made from other funding sources as well as the Department of Mental Health.

Prior to utilization, the survey was reviewed by two mental retardation program administrators, three parents of mentally retarded individuals, two Franklin/Hampshire Area Office mental retardation staff members, and three special education college instructors. The survey was revised according to their suggestions. A copy of the survey can be found in Appendix C.

**Data Collection Procedures**

1) A letter of support, which can be found in Appendix D, was requested and received from the Franklin/Hampshire Area Director of the Department of Mental Health. A copy of this letter accompanied letters explaining the process to and requesting assistance from administrators of residential services, directors of Franklin/Hampshire County Association of Retarded Citizens and the Franklin/Hampshire Area Board (See Appendix E).

2) A letter was sent to the Franklin and Hampshire County Associations for Retarded Citizens describing the survey and requesting their assistance in the form of making available their current membership list (See Appendix E). A meeting was held with each Association for Retarded Citizens to review their membership list indicating and coding the
following:

a) Members who are parents/guardians of a mentally retarded individual.

b) Members who are not parents/guardians but, by their membership, are concerned with the plight of the retarded.

A copy of the survey together with a letter of support from each Association for Retarded Citizens director and a stamped addressed envelope to expedite their return was sent to each member.

3) Following the letter mentioned in #1, a meeting was held with the members of the Franklin/Hampshire Area Board. The intent of the study and survey was discussed and each member attending was given a copy of the survey, coded to indicate area board membership, and a stamped addressed envelope to expedite their return. Members not attending this meeting received their surveys by mail.

4) A telephone call followed up the letter to the directors of residential programs. During this call we agreed upon:

a) The number of administrator surveys needed.

b) The number of direct staff surveys needed.

c) A delivery date for the surveys.

d) A pick-up date for the completed surveys.
Data Analysis

The results of this study were analyzed in two phases. In the first phase, each of the four groups responding was analyzed and summarized as to their responses to the survey questions. Each group response was tabulated and the results indicated on group comparison tables which can be found in Chapter IV.

The second phase of the analysis of the data was concerned with determining the common characteristics which need to be addressed in developing a residential prototype. This information is broken out in Chapter IV under four main categories:

1) Residential staff qualifications
2) Program size/makeup.
3) Program location
4) Program responsibility

The information compiled from the four responding groups was cross-tabulated with regard to the above mentioned categories.

Appendix F indicates the survey questions corresponding with the four main categories.

A survey summary indicating the total numerical responses for each available choice appears in Appendix G.
CHAPTER IV
RESULTS

This chapter reports the responses to the survey questionnaire administered to program administrators, direct care staff of residential programs for mentally retarded individuals, parents of mentally retarded individuals and concerned citizens. A copy of the survey questionnaire is provided in Appendix C.

The responses of the survey have been broken out in the following five categories:

1) Franklin County Association for Retarded Citizens parents (hereafter referred to as FCARC).

2) Hampshire County Association for Retarded Citizens parents (hereafter referred to as HCARC).

3) Concerned citizens - members of the Franklin/Hampshire Department of Mental Health Area Board and members of both the Franklin and Hampshire Associations for Retarded Citizens who are not parents or guardians of mentally retarded individuals.

4) Direct care staff of residential programs for mentally retarded individuals.

5) Administrators of residential programs for mentally retarded individuals.

The survey results represent a 68% return to the questionnaire as indicated in Table 1. According to George
<table>
<thead>
<tr>
<th>Group</th>
<th># Sent</th>
<th># Returned</th>
<th>% Return</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCARC Parents</td>
<td>53</td>
<td>41</td>
<td>77</td>
</tr>
<tr>
<td>HCARC Parents</td>
<td>47</td>
<td>30</td>
<td>63</td>
</tr>
<tr>
<td>FCARC Concerned Citizens</td>
<td>25</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>HCARC Concerned Citizens</td>
<td>25</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>Area Board*</td>
<td>5</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>50</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>Administrators</td>
<td>14</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>219</strong></td>
<td><strong>149</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

*Included as part of the concerned citizens group in the analysis of this dissertation data.*
J. Mouly (1970), an average percent of return for reputable questionnaire studies is 65%.

Data Analysis

The categories of data presentation used for the results of the survey are (See Appendix F):

1) Residential staff qualifications/questions 1-3 of survey.
2) Program size/makeup questions 4-9 and 34 of survey.
3) Program location/questions 10-22 of survey.
4) Program responsibility/questions 23-33, 35, 36, of survey.

The breakdown of categories was derived from the questionnaire design.

1. Residential Staff Qualifications

A collective tabulation of the data from the five responding groups indicates desire for highly trained residential staff. Graduation from high school and/or college with additional professional training, certification in special education and prior working experience with the mentally retarded were viewed as preferable employment prerequisites.

A cross-tabulation of the five groups indicate that 60.7% of the concerned citizens, 50% of the administrators and 53.3% of the direct care staff feel that the minimum educational requirement for employment in a residential
program for mentally retarded individuals should be high school. Only 30.8% of the FCARC parents and 19.2% of the HCARC parents share the same view.

28.2% of the FCARC parents, 19.2% of the HCARC parents and 14.3% of the concerned citizens feel that the educational employment minimum requirement should be graduation from college. 16.7% of the direct care staff and 8.3% of the administrators concur with this requirement.

41% of the FCARC parents, 57.7% of the HCARC parents, and 41.7% of the administrators indicated that they view graduation from college plus additional professional training should be the minimum educational requirement for employment. This view was shared by only 26.7% of the direct care staff and 25% of the concerned citizens.

Table 2 illustrates the cross-tabulation of this data.

Certification. 60% of the FCARC parents, 75.8% of the HCARC parents and 56.7% of the concerned citizens indicated that they strongly approve or approve of certification for residential staff members whereas only 42.8% of the administrators and 43.7% of the direct care staff feel the same.

25% of the FCARC parents, 20.7% of the HCARC parents, 23.3% of the concerned citizens and 35.7% of the administrators disapprove or strongly disapprove of certification whereas 50% of the direct care staff responded in the negative.
TABLE 2

MINIMUM EDUCATIONAL REQUIREMENTS
(By Percentage)

<table>
<thead>
<tr>
<th>Group</th>
<th>Grad. From Grade School</th>
<th>Grad. From Jr. High</th>
<th>Grad. From High School</th>
<th>Grad. From College</th>
<th>College Grad. +</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCARC</td>
<td>0</td>
<td>0</td>
<td>30.8</td>
<td>28.2</td>
<td>41.0</td>
</tr>
<tr>
<td>HCARC</td>
<td>3.8</td>
<td>0</td>
<td>19.2</td>
<td>19.2</td>
<td>57.7</td>
</tr>
<tr>
<td>Concerned Citizens</td>
<td>0</td>
<td>0</td>
<td>60.7</td>
<td>14.3</td>
<td>25.0</td>
</tr>
<tr>
<td>Administrators</td>
<td>0</td>
<td>0</td>
<td>50.0</td>
<td>8.3</td>
<td>41.7</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>0</td>
<td>3.3</td>
<td>53.3</td>
<td>16.7</td>
<td>26.7</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>0.76</td>
<td>0.66</td>
<td>42.8</td>
<td>17.3</td>
<td>38.4</td>
</tr>
</tbody>
</table>
21% of the administrators, 20% of the concerned citizens and 15% of the FCARC parents were undecided on this issue whereas only 3.4% of the HCARC parents and 6.3% of the direct care staff found it difficult to decide.

Table 3 illustrates the cross-tabulation of this data.

Prior experience. 92% of the FCARC parents, 96.6% of the HCARC parents and 93.1% of the concerned citizens strongly approve or approve of residential staff having prior residential employment experience with mentally retarded/special needs individuals. 71.4% of the administrators and 78.1% of the direct care staff viewed this as an important prerequisite.

28.6% of the administrators and 21.9% of the direct care staff disapproved or strongly disapproved of prior residential employment as a prerequisite to employment whereas only 7.5% of the FCARC parents, 3.3% of the HCARC parents and 6.9% of the concerned citizens felt prior experience was not necessary. No group was undecided on this issue.

Table 4 illustrates the cross-tabulation of this data.

2. Program Size/Makeup

A collective tabulation of data from the five responding groups indicated favorable attitudes toward residential programs for mentally retarded individuals which would be:
### TABLE 3

**CERTIFICATION OF RESIDENTIAL STAFF**

<table>
<thead>
<tr>
<th>Group</th>
<th>Strongly Approve % Response</th>
<th>Approve % Response</th>
<th>Undecided % Response</th>
<th>Disapprove % Response</th>
<th>Strongly Disapprove % Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCARC</td>
<td>32.5</td>
<td>27.5</td>
<td>15.0</td>
<td>20.0</td>
<td>5.0</td>
</tr>
<tr>
<td>HCARC</td>
<td>31.0</td>
<td>44.8</td>
<td>3.4</td>
<td>20.7</td>
<td>0</td>
</tr>
<tr>
<td>Concerned Citizens</td>
<td>30.0</td>
<td>26.7</td>
<td>20.0</td>
<td>20.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Administrators</td>
<td>7.1</td>
<td>35.7</td>
<td>21.4</td>
<td>28.6</td>
<td>7.1</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>3.1</td>
<td>40.6</td>
<td>6.3</td>
<td>40.6</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>AVERAGE</strong></td>
<td><strong>20.7</strong></td>
<td><strong>35.1</strong></td>
<td><strong>13.2</strong></td>
<td><strong>26.0</strong></td>
<td><strong>5.0</strong></td>
</tr>
<tr>
<td>Group</td>
<td>Strongly Approve % Response</td>
<td>Approve % Response</td>
<td>Disapprove % Response</td>
<td>Strongly Disapprove % Response</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------</td>
<td>-------------------</td>
<td>-----------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>FCARC</td>
<td>50.0</td>
<td>42.5</td>
<td>7.5</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>HCARC</td>
<td>43.3</td>
<td>53.3</td>
<td>3.3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Concerned Citizens</td>
<td>34.5</td>
<td>58.6</td>
<td>6.9</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Administrators</td>
<td>21.4</td>
<td>50.0</td>
<td>28.6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>25.0</td>
<td>53.1</td>
<td>18.8</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>AVERAGE</td>
<td>35.0</td>
<td>52.0</td>
<td>13.0</td>
<td>0.62</td>
<td></td>
</tr>
</tbody>
</table>
1) limited to five to seven residents of similar skills and abilities,
2) co-educational in resident make up and,
3) composed of residents of similar age grouping.

**Number of Residents.** A cross-tabulation of the five groups indicated that 7.7% of the FCARC parents, 7.1% of the HCARC parents and 7.4% of the concerned citizens feel that residential programs should not be held to any specific number of occupants. 3.4% of the direct care staff share this view whereas none of the administrators do.

20.5% of the FCARC parents, 21.4% of the HCARC parents and 14.8% of the concerned citizens feel that residential programs should be limited to nine residents. 6.9% of the direct care staff share this view whereas none of the administrators agree with this view.

28.2% of the FCARC parents, 35.7% of the HCARC parents and 14.8% of the concerned citizens feel that residential programs should be limited to seven residents. 10.3% of the direct care staff also share this view whereas only 7.1% of the administrators concur.

78.6% of the administrators, 69% of the direct care staff and 51.9% of the concerned citizens feel that residential programs should be limited to five residents whereas 21.4% of the HCARC parents and 38.5% of the FCARC parents support this view.
14.3% of the HCARC parents and 14.3% of the administrators feel that residential programs should be limited to three whereas only 5.1% of the FCARC parents, 11.1% of the concerned citizens and 10.3% of the direct care staff agree with this view.

Table 5 illustrates the cross-tabulation of this data.

Co-Educational. 85.8% of the administrators, 83.4% of the concerned citizens and 81.9% of the direct care staff strongly approve or approve of co-educational residential programming. 14.3% of the administrators, 13.3% of the concerned citizens and 18.2% of the direct care staff were undecided on this issue.

76.6% of the HCARC parents and 70% of the FCARC parents strongly approve or approve of co-educational residential programming. 13.3% of the HCARC parents are undecided on this issue, compared to 15% of the FCARC parents.

15% of the FCARC parents disapprove or disapprove strongly regarding co-educational programming whereas only 10% of the HCARC parents and 3.3% of the concerned citizens disapprove on this issue. None of the administrators or direct care staff disapprove of co-educational programming.

Table 6 illustrates the cross-tabulation of this data.

Similar Needs. 81.6% of the FCARC parents, 81.3% of the direct care staff and 78.6% of the administrators feel that
TABLE 5
RESIDENTIAL OCCUPANCY LIMITS

<table>
<thead>
<tr>
<th>Group</th>
<th>Unlimited % Response</th>
<th>Limit 9 % Response</th>
<th>Limit 7 % Response</th>
<th>Limit 5 % Response</th>
<th>Limit 3 % Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCARC</td>
<td>7.7</td>
<td>20.5</td>
<td>28.2</td>
<td>38.5</td>
<td>5.1</td>
</tr>
<tr>
<td>HCARC</td>
<td>7.1</td>
<td>21.4</td>
<td>35.7</td>
<td>21.4</td>
<td>14.3</td>
</tr>
<tr>
<td>Concerned Citizens</td>
<td>7.4</td>
<td>14.8</td>
<td>14.8</td>
<td>51.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Administrators</td>
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<td>0</td>
<td>7.1</td>
<td>78.6</td>
<td>14.3</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>3.4</td>
<td>6.9</td>
<td>10.3</td>
<td>69.0</td>
<td>10.3</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>5.1</td>
<td>13.0</td>
<td>19.2</td>
<td>52.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Group</td>
<td>Strongly Approve % Response</td>
<td>Approve % Response</td>
<td>Undecided % Response</td>
<td>Disapprove % Response</td>
<td>Strongly Disapprove % Response</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------</td>
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<td>----------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>FCARC</td>
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<td>60.0</td>
<td>15.0</td>
<td>12.5</td>
<td>2.5</td>
</tr>
<tr>
<td>HCARC</td>
<td>33.3</td>
<td>43.3</td>
<td>13.3</td>
<td>10.0</td>
<td>0</td>
</tr>
<tr>
<td>Concerned Citizens</td>
<td>26.7</td>
<td>56.7</td>
<td>13.3</td>
<td>3.3</td>
<td>0</td>
</tr>
<tr>
<td>Administrators</td>
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<td>Direct Care Staff</td>
<td>45.5</td>
<td>36.4</td>
<td>18.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>31.7</td>
<td>47.9</td>
<td>14.8</td>
<td>5.2</td>
<td>.5</td>
</tr>
</tbody>
</table>
residential programs should be composed of individuals with similar needs. 72.4% of the HCARC parents and 70% of the concerned parents share this view.

17.2% of the HCARC parents, 16.6% of the concerned citizens and 10.5% of the FCARC parents strongly disapproved of disapproved of residential programs composed of individuals with similar needs. However, 6.3% of the direct care staff and none of the administrators strongly disapprove or disapprove of this concept.

21.4% of the administrators, 13.3% of the concerned citizens, and 12.5% of the direct care staff were undecided regarding programs being composed of individuals with similar needs. Only 10.3% of the HCARC parents and 7.9% of the FCARC parents were undecided on this issue.

Table 7 illustrates the cross-tabulation of this data.

**Similar age grouping.** 76.3% of the FCARC parents, 68.9% of the concerned citizens and 64.3% of the administrators strongly approve or approve of residential programs being composed of residents of similar age grouping. 60.7% of the HCARC parents and 54.5% of the direct care staff share this view.

21.4% of the administrators, 18.2% of the direct care staff, 17.9% of the HCARC parents and 15.9% of the FCARC parents strongly disapprove or disapprove of similar age grouping for residential programs for mentally retarded


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individuals.

27.3% of the direct care staff, 20.7% of the concerned citizens and 21.4% of the HCARC parents were undecided on this issue whereas only 14.3% of the administrators and 7.9% of the FCARC parents could not decide.

Table 8 illustrates the cross-tabulation of this data.

3. Program Location

A collective tabulation of the data related to the location of residential programs for the mentally retarded indicates that the majority of the five responding groups feel residential programs should be located in the community, near the center of towns and cities and, when adequate transportation is available, in suburban areas.

Institutions and institutional complexes such as hospitals, nursing homes, apartment complexes and intermediate care facilities were not viewed as favorable residential programming locations.

Duplex apartment houses, two family type structures and single family residences situated on secondary streets are considered to be the most suitable community residential programming sites.

A cross-tabulation of the five groups indicates that 100% of the administrators, 96.9% of the direct care staff, 90% of the HCARC parents, 89.8% of the FCARC parents and 80% of the concerned citizens strongly approve or approve
TABLE 8
RESIDENTIAL PROGRAMS COMPOSED OF SIMILAR AGE GROUPING

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of the mentally retarded living in the community.

2.6% of the FCARC parents, 3.3% of the concerned citizens and 3.0% of the direct care staff strongly disapprove or disapprove of the retarded living in the community. None of the HCARC parents or administrators share this feeling.

16.7% of the concerned citizens, 10% of the HCARC parents and 7.7% of the FCARC parents were undecided. None of the administrators or direct care staff were undecided on this issue.

Table 9 illustrates the cross-tabulation of this data.

Center of towns/cities. 85.7% of the administrators, 70.9% of the direct care staff and 60% of the HCARC parents strongly approve or approve locating residential programs for retarded/special needs individuals near the center of towns or cities. 42.8% of the concerned citizens and 53.8% of the FCARC parents indicated the same feelings regarding program location.

30.8% of the FCARC parents, 23.9% of the HCARC parents and 35.7% of the concerned citizens strongly disapprove or disapprove of locating programs near centers of towns or cities. Only 16.2% of the direct care staff and 7.1% of the administrators indicated similar feelings.

15.4% of the FCARC parents, 16.7% of the HCARC parents and 21.4% of the concerned citizens were undecided on this
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issue. 7.1% of the administrators and 12.9% of the direct care staff also indicated an undecided response on this issue.

Table 10 illustrates the cross-tabulation of this data.

Suburban area. 75% of the administrators, 66.6% of the HCARC parents, 59% of the FCARC parents and 62% of the concerned citizens strongly approve or approve of locating residential programs in suburban areas. 34.5% of the direct care staff shared this view.

37.9% of the direct care staff and 25.7% of the FCARC parents indicated a strong disapproval or disapproval of locating residential programs in a suburban area. This feeling was mirrored by 20.7% of the concerned citizens, 13.3% of the HCARC parents and 8.3% of the administrators.

27.6% of the direct care staff and 20% of the HCARC parents were undecided on this program placement issue. 15.4% of the FCARC parents, 17.2% of the concerned citizens, and 16.7% of the administrators are also undecided on this issue.

Table 11 illustrates the cross-tabulation of this data.

Institutional programming. 13.1% of the FCARC parents, 6.9% of the HCARC parents, 7.2% of the concerned citizens and 9.4% of the direct care staff strongly approve or approve of residential programming for the mentally retarded being on the grounds of an institution. However, none of
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the administrators surveyed shared this feeling.

10.7% of the concerned citizens, 7.9% of the FCARC parents, 6.9% of the HCARC parents and 6.3% of the direct care staff surveyed were undecided on this issue, whereas none of the administrators were.

86.2% of the HCARC parents, 84.4% of the direct care staff, 82.2% of the concerned citizens and 78.9% of the FCARC parents strongly disapprove or disapprove of residential programming on institutional grounds. This view is shared by 100% of the administrators surveyed.

Table 12 illustrates the cross-tabulation of this data.

**Apartment complexes.** 24.3% of the FCARC parents, 23.3% of the direct care staff, and 23.1% of the administrators strongly approve or approve of residential programming for the mentally retarded being in apartment complexes. 20.7% of the HCARC parents and 17.8% of the concerned citizens shared this view.

62% of the HCARC parents, 57.2% of the concerned citizens and 56.7% of the FCARC parents strongly disapprove or disapprove of residential programs being located in apartment complexes. Only 46.2% of the administrators and 40% of the direct care staff indicated the same feelings.

36.7% of the direct care staff, 30.8% of the administrators and 25% of the concerned citizens were undecided concerning apartment complexes being suitable sites for
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residential programs. 18.9% of the FCARC parents and 17.2% of the HCARC parents were also undecided on this issue.

Table 13 illustrates the cross-tabulation of this data.

**Apartment/duplex.** 66.7% of the administrators, 60% of the HCARC parents, 54.8% of the direct care staff, 51.7% of the concerned citizens and 50% of the FCARC parents strongly approve or approve of residential programs for the mentally retarded being located in duplex or two family type apartment structures.

34.5% of the concerned citizens, 27.5% of the FCARC parents and 30% of the HCARC parents strongly disapprove or disapprove of residential programs for the mentally retarded located in duplex or two family type structures. Only 16.7% of the administrators and 16.1% of the direct care staff share this attitude.

29% of the direct care staff, 22.5% of the FCARC parents and 16.7% of the administrators are undecided regarding duplex or two family structures as programming locations, whereas only 13.8% of the concerned citizens and 10% of the HCARC parents were undecided.

Table 14 illustrates the cross-tabulation of this data.

**Single family.** 100% of the administrators, 77.8% of the concerned citizens, 76.3% of the FCARC parents and 75% of the HCARC parents strongly approve or approve programs
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for mentally retarded being located in single family residences. 64.6% of the direct care staff shared that view.

16.1% of the direct care staff, 13.2% of the FCARC parents and 10.7% of the HCARC parents strongly disapprove or disapprove of programs for mentally retarded in single family residences. However, none of the administrators or concerned citizens felt this way.

22% of the concerned citizens, 19.4% of the direct care staff and 14.3% of the HCARC parents were undecided whereas only 10.5% of the FCARC parents and none of the administrators were undecided.

Table 15 illustrates the cross-tabulation of this data.

Institutional complexes. 23.4% of the HCARC parents, 19.5% of the FCARC parents, 14.2% of the concerned citizens and 12.9% of the direct care staff strongly approve or approve of the institutional complex, i.e. nursing homes, hospitals, intermediate care facilities, etc., as a suitable location for residential programs for the mentally retarded. None of the administrators surveyed share this attitude.

100% of the administrators, 89.7% of the direct care staff and 71.4% of the concerned citizens strongly disapprove or disapprove of institutional complexes as residential program location sites whereas 66.6% of the HCARC and 63.9% of the FCARC parents share the same feeling.

16.7% of the FCARC and 10% of the HCARC parents were
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undecided, while 14.3% of the concerned citizens, 6.5% of the direct care staff and 0% of the administrators mirrored this same feeling.

Table 16 illustrates the cross-tabulation of this data.

**Secondary streets.** 91.6% of the administrators, 83.9% of the FCARC and 80% of the HCARC parents surveyed strongly approved or approved of secondary streets as the location for programs for mentally retarded individuals. 60.2% of the concerned citizens and 56.6% of the direct care staff feel the same.

13.4% of the direct care staff and 10% of the HCARC parents strongly disapprove or disapprove with residential programs located on secondary streets whereas only 6.4% of the FCARC parents, 4% of the concerned citizens and none of the administrators share this attitude.

30% of the direct care staff and 36% of the concerned citizens are undecided on this issue while only 9.7% of the FCARC parents, 10% of the HCARC parents and 8.3% of the administrators are uncertain on this issue.

Table 17 illustrates the cross-tabulation of this data.

**Community based settings.** Retarded/special needs individuals receiving residential programming primarily within community based settings was strongly approved or approved by 100% of the administrators, 96.6% of the HCARC parents, 93.3% of the concerned citizens, and 87.9% of the direct care
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<td>65.0</td>
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</table>
staff, whereas 76.9% of the FCARC parents support this view.

7.7% of the FCARC parents strongly disapprove or disapprove of community based residential settings and 9.1% of the direct care staff share this attitude. However, none of the HCARC parents, concerned citizens or administrators expressed the same feelings.

15.6% of the FCARC parents and 6.7% of the concerned citizens were undecided on this issue while 3.4% of the HCARC parents, 3% of the direct care staff and none of the administrators expressed uncertainty.

Table 18 illustrates the cross-tabulation of this data.

4. Program Responsibility

A collective tabulation of the data from the five groups suggested that residential programs for mentally retarded individuals should assume major responsibility for

1) supervision of program residents,
2) training/tutoring program residents,
3) planning leisure time activities for program residents,
4) transporting residents to and from leisure time activities, and
5) providing sex education for program residents.

In addition, based on the skill level and needs of the residents, the program focus should be on self help skills
TABLE 18

RESIDENTIAL PROGRAMMING WITHIN COMMUNITY BASED SETTINGS

<table>
<thead>
<tr>
<th>Group</th>
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<tr>
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<td>28.6</td>
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<tr>
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<td>46.7</td>
<td>5.7</td>
<td>2.2</td>
<td>1.1</td>
</tr>
</tbody>
</table>
(hygiene care, dressing, food preparation, communication, etc.) and interpersonal skill building (control of temper, courtesy to others, obeying rules and laws, etc.).

**Supervision.** A cross-tabulation of the five groups denotes that 85.7% of the HCARC parents and 73.7% of the FCARC parents strongly approve or approve supervision as the most important responsibility of residential staff members whereas 66.6% of the concerned citizens, 50% of the administrators and 46.6% of the direct care staff share the same view.

42.9% of the administrators, 36.6% of the direct care staff and 22.2% of the concerned citizens strongly disapprove or disapprove of supervision being the most important responsibility. Only 15.8% of the FCARC parents and 7.1% of the HCARC parents surveyed agree with this attitude.

16.7% of the direct care staff, 10.5% of the FCARC parents and 11.1% of the concerned citizens were undecided on this question whereas only 7.1% of the HCARC parents and 7.1% of the administrators indicated uncertainty.

Table 19 illustrates the cross-tabulation of this data.

**Training/tutoring.** Training/tutoring is strongly approved or approved as the most important residential staff responsibility by 83.3% of the HCARC parents and 82.8% of the direct care staff whereas 78.5% of the concerned citizens, 77% of the administrators and 68.4% of the FCARC parents
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<tr>
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<td>35.3</td>
<td>10.5</td>
<td>23.7</td>
<td>1.2</td>
</tr>
</tbody>
</table>
share the same view.

26.3% of the FCARC parents, 15.4% of the administrators and 14.3% of the concerned citizens strongly disapproved or disapproved of training/tutoring as the most important residential staff responsibility. 6.7% of the HCARC parents and none of the direct care staff surveyed agreed with this view.

17.2% of the direct care staff and 10% of the HCARC parents were undecided on this question whereas only 5.3% of the FCARC parents, 7.1% of the concerned citizens and 7.7% of the administrators were undecided.

Table 20 illustrates the cross-tabulation of this data.

Transportation responsibility. None of the administrators surveyed viewed the parents/guardians of the retarded involved in residential programs responsible for transportation for leisure time activities. 19.4% of the FCARC parents, 8.3% of the HCARC parents, 11.1% of the concerned citizens and 4.5% of the direct care staff viewed leisure time transportation as the responsibility of the parents/guardians of residents served by the program.

HCARC parents, administrators of residential programs and direct care staff do not view the local school system as the responsible enterprise for leisure time transportation. However, 5.6% of the FCARC parents and 3.7% of the concerned citizens view the schools as being responsible.
<table>
<thead>
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<th>Undecided % Response</th>
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</tbody>
</table>
25% of the HCARC parents, 18.5% of the concerned citizens and 13.9% of the FCARC parents surveyed view the Department of Mental Health as being responsible for leisure time activities transportation whereas only 4.5% of the direct care staff and none of the administrators shared this view.

87.5% of the administrators surveyed viewed the residential staff as having the major responsibility for leisure time activities transportation. This same attitude was expressed by 58.3% of the HCARC parents, 45.5% of the direct care staff, 41.7% of the FCARC parents and 40.7% of the concerned citizens.

The use of existing community transportation systems was viewed as the method responsible for residential program leisure time transportation by 45.5% of the direct care staff and 25.9% of the concerned citizens. 19.4% of the FCARC parents, 12.5% of the administrators and 8.3% of the HCARC parents view this system as acceptable.

Table 21 illustrates the cross-tabulation of this data.

Leisure planning program. All of the administrators surveyed strongly approved or approved of the residential program taking the responsibility for planning leisure time activities for the residents. This attitude was shared by 96.3% of the HCARC parents, 84.2% of the FCARC parents, 83.3% of the concerned citizens and 74.2% of the
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<td><strong>54.7</strong></td>
<td><strong>22.3</strong></td>
</tr>
</tbody>
</table>
direct care staff.

10% of the concerned citizens, 9.7% of the direct care staff and 5.2% of the FCARC parents strongly disapprove or disapprove of programs planning leisure time activities for its residents. Only 3.3% of the HCARC parents and none of the administrators share this view.

16.1% of the direct care staff, 10.5% of the FCARC parents and 6.7% of the concerned citizens were undecided on this question whereas both the administrators and HCARC parents were not.

Table 22 illustrates the cross-tabulation of this data.

Responding to unacceptable behavior.

A. Confinement. For residents exhibiting unacceptable behavior, 61.1% of the FCARC parents, 60.7% of the HCARC parents and 55.1% of the concerned citizens strongly approve or approve of confining the individual to the residence. 20% of the direct care staff and 7.7% of the administrators agree that this is acceptable.

69.3% of the administrators and 50% of the direct care staff strongly disapprove or disapprove of residents who consistently exhibit unacceptable behavior being confined to the residence. 34.4% of the concerned citizens, 33.3% of the FCARC parents and 21.4% of the HCARC parents shared this attitude.

30% of the direct care staff, 23.1% of the
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<th>% Response</th>
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<tr>
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<td>7.0</td>
<td>3.2</td>
<td>2.5</td>
<td></td>
<td></td>
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</tr>
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</table>
administrators and 17.9% of the HCARC parents were undecided and 10.3% of the concerned citizens and 5.6% of the FCARC parents were uncertain regarding this question.

Table 23 illustrates the cross-tabulation of this data.

B. Reprimanding. There was some consistency regarding the attitude expressed pertaining to mentally retarded residents being reprimanded for unacceptable behavior. 83% of the administrators strongly approve or approve of residents being reprimanded for unacceptable behavior, as did 82.3% of the concerned citizens and 82.8% of the HCARC parents, 80.6% of the FCARC and 73.3% of the direct care staff.

No one indicated a strong disapproval regarding reprimanding residents. However, 13.9% of the FCARC parents, 10.3% of the HCARC parents, 10.7% of the concerned citizens, 8.3% of the administrators and 3.3% of the direct care staff did indicate disapproval.

8.3% of the administrators, 7.1% of the concerned citizens, 6.9% of the HCARC parents and 5.6% of the FCARC parents were undecided on this issue whereas 23.3% of the direct care staff felt the same.

Table 24 illustrates the cross-tabulation of this data.

C. Intensive daily training. All of the HCARC parents strongly approve or approve of intensive daily training for unacceptable residential behavior. This view is shared by 93.6% of the direct care staff, 87.2% of the FCARC parents,
<table>
<thead>
<tr>
<th>Group</th>
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<td>17.4</td>
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### TABLE 24

**Residents Exhibiting Unacceptable Behavior Should Be Reprimanded**

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<tr>
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<tr>
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<tr>
<td><strong>Average</strong></td>
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<td><strong>60.9</strong></td>
<td><strong>10.2</strong></td>
<td><strong>3.3</strong></td>
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</tbody>
</table>
86.2% of the concerned citizens and 75% of the administrators.

10.3% of the FCARC parents, 10.3% of the concerned citizens and 8.3% of the administrators strongly disapprove or disapprove of this method. There was negative disapproval on the part of the HCARC parents and direct care staff.

16.7% of the administrators were undecided on this issue while 6.5% of the direct care staff, 3.4% of the concerned citizens and 2.6% of the FCARC parents indicated uncertainty. None of the HCARC parents were undecided on this issue.

Table 25 illustrates the cross-tabulation of this data.

Sex education. The issue of residential programs providing sex education was strongly approved or approved by 96.7% of the direct care staff. This view was shared by 85.7% of the administrators, 83.4% of the concerned citizens, 83.3% of the HCARC parents and 79.5% of the FCARC parents.

10.3% of the FCARC parents strongly disapprove or disapprove of residential programs providing sex education. 7.1% of the administrators and 3.3% of the HCARC parents share the same view while concerned citizens and direct care staff indicated no disapproval whatsoever.

16.7% of the concerned citizens were undecided on the issue of sex education. This uncertainty was expressed by
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</thead>
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</tr>
<tr>
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<tr>
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<td><strong>45.3</strong></td>
<td><strong>5.8</strong></td>
<td><strong>3.4</strong></td>
<td><strong>2.3</strong></td>
</tr>
</tbody>
</table>
13.3% of the HCARC parents, 10.3% of the FCARC parents, 7.1% of the administrators and 3.3% of the direct care staff.

Table 26 illustrates the cross-tabulation of this data.

**Minimum staff ratio.** 20% of the administrators viewed one staff for every resident as the minimum staffing ratio for residential programs. This staffing ratio was supported by 7.7% of the HCARC parents, 4% of the concerned citizens, 3.8% of the direct care staff and 2.9% of the FCARC parents.

61.5% of the direct care staff viewed one staff for every two residents as the minimum staffing ratio for residential programs. This ratio was supported by 60% of the administrators, 32% of the concerned citizens, 28.6% of the FCARC parents and 15.4% of the HCARC parents.

One staff for every three residents was supported as the minimum staffing ratio for residential programs by 53.8% of the HCARC parents, 48.6% of the FCARC parents, 40% of the concerned citizens, 20% of the administrators and 19.2% of the direct care staff.

24% of the concerned citizens, 19.2% of the HCARC parents, 15.4% of the direct care staff and 14.3% of the FCARC parents felt that one staff for every four residents should be the minimum residential staffing ratio. No administrators surveyed supported this view.

One staff for every five residents was chosen as the minimum staffing ratio for residential programs by 5.7% of
<table>
<thead>
<tr>
<th>Group</th>
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<th>Disapprove % Response</th>
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<td>36.7</td>
<td>16.7</td>
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<td>0</td>
</tr>
<tr>
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<td>50.0</td>
<td>7.1</td>
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<tr>
<td>Direct Care Staff</td>
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<td>36.7</td>
<td>3.3</td>
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</tr>
<tr>
<td>AVERAGE</td>
<td>41.1</td>
<td>44.6</td>
<td>10.1</td>
<td>3.6</td>
<td>.5</td>
</tr>
</tbody>
</table>
the FCARC parents and 3.8% of the HCARC parents. No concerned citizens, administrators or direct care staff surveyed indicated this preference.

Table 27 illustrates the cross-tabulation of this data.
### TABLE 27

**MINIMUM STAFF RATIO**

<table>
<thead>
<tr>
<th>Group</th>
<th>1:1 % Response</th>
<th>1:2 % Response</th>
<th>1:3 % Response</th>
<th>1:4 % Response</th>
<th>1:5 % Response</th>
</tr>
</thead>
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<tr>
<td>FCARC</td>
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<td>48.6</td>
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<tr>
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<td>60.0</td>
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<td>0</td>
</tr>
<tr>
<td>Direct Care Staff</td>
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<td>19.2</td>
<td>15.4</td>
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<tr>
<td><strong>AVERAGE</strong></td>
<td><strong>8.0</strong></td>
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<td><strong>36.3</strong></td>
<td><strong>15.0</strong></td>
<td><strong>2.0</strong></td>
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CHAPTER V
DISCUSSION AND CONCLUSIONS

This chapter explores the four program areas responded to in the questionnaire and provides a framework for the development of a residential living/learning system for formerly institutionalized mentally retarded individuals.

1. Staff Qualifications

Many residential programs, due to funding limitations, labor force availability, and/or lack of training components or educational institutional ties, do not have many staff who are qualified or credentialed via formal training or experience. Because of this, programs and staff have had to maintain instead of train mentally retarded residents. The retarded resident potential for growth, development, and learning is stimulated because those in a position of guidance do not have the skills to guide. Such situations, according to Wolfensberger (1975), do little more than promote the stigma of the retarded as "objects of pity" and "burdens of charity."

Few would disagree that the merit of any residential program rests in the caliber of the staff involved. The results of this study indicate that parents tend to view staff ability primarily in terms of services (teaching, training, experiences etc.) rendered to program residents.
They expect these areas of staff expertise to be backed up by college degrees, special professional training and/or previous residential, special programming experience.

On the other hand, Mr. & Mrs. Citizen are comfortable with residential staff having high school educations plus special professional training. They tend to view staff ability in terms of visible program structure (resident supervision, program rules, degree of community involvement).

Comments written by the residential staff indicate that they view educational needs related to the capability of the residents in the program. They feel that a high school and/or college degree are important, but more important is the professional training in direct relationship to their job.

The administrator is caught between desire and reality. They desire each of their staff to be college degreed, professionally trained and/or experienced. However, they are satisfied with high school graduates or experienced individuals who are willing to learn and be trained on the job. Realistically their budgets will not support a pay scale competitive with schools and institutions.

It is evident that education or training culminating in certificates or credentials indicating an understanding of, involvement with, or an ability to provide services to the mentally retarded is necessary. It would appear that the best way for current residential programs to meet this need is by developing their own ongoing training/inservice
programs. These inservice programs should be developed around the needs of staff, parents and/or residents and conducted by specially trained individuals or consultants. Individuals completing the programs could be awarded a certificate of completion. For staff, this could be used in part to determine advancements, merit pay, and professional enrichment evaluation.

Each residential program should develop a proletarian and professional career ladder indicating at a minimum, job descriptions, job qualifications, areas of evaluations, supervisor, criteria for advancement, hours, and minimum and maximum salary.

Training and workshops in connection with career development can be tied into the community educational system. The use of high school courses, special agency courses such as red cross first aid and swimming classes, college and university courses which relate to program ideology and resident development will enhance the inservice program plus pay off in credits and certificates of completions.

Comments written on the survey regarding training and courses for residential staff suggest the need for information pertaining to the psychological and educational problems faced by mentally retarded individuals. Such information is usually covered in a basic introductory course on mental retardation and can be easily included in
an inservice program. Additionally, information regarding normalization and the social aspects of mental retardation should be included. This basic information would give the staff a better understanding of the perimeter of expectation on the part of community, staff and residents.

In summary, residential direct care staff view prior employment related to the field of special education and/or a high school education as a necessary minimum employment requirement. This is probably due to the fact that a large percentage of the direct care staff currently employed in the Franklin/Hampshire residential system are high school graduates. Department of Mental Health Area Office records indicate that over fifty percent of these individuals have prior experience with the mentally retarded through summer camps, school programs and institutions such as Belchertown State School. Approximately thirty percent of those employed are currently enrolled or have been enrolled in institutions of higher education concentrating in special education or a related field of study.

Direct care staff do not favor certification because many do not view residential services as a profession. The high degree of staff turnover reported to the area office by program vendors indicate that many direct care staff view their employment as a temporary situation until something better surfaces. The vendor pay scale and employee benefits do not encourage and/or support an air
of professionalism. Before certification can be supported by direct care staff an attitude of professional worth must be developed.

Parents and administrators support college education, certification and prior employment as a minimum employment requirement. This is probably due to the fact that these criteria reflect a degree of quality and understanding of residential programming and individuals to be served. However, the reality of this situation is directly tied to the current economic situation. Under present funding constraints, vendors can not attract individuals meeting all three of these criteria.

Citizens, perhaps due to their lack of understanding of the residential system and those served by it, view certification and prior experience as a mechanism of quality more so than education. Citizen survey comments indicated that they view a willingness to work with the mentally retarded on the part of those employed more valuable than specifically employing college educated individuals. This indicates that many do not view the mentally retarded as individuals of worth. Supervision and companionship is more important than the educational instruction that could be provided by a college degreeed individual. Some indicated that a college degree requirement for residential employment would unnecessarily inflate the residential budget.
2. Program Size/Makeup

Most of the individuals surveyed indicated that a staff to resident staffing ratio should be based on the needs of the residents involved in the program. The greater the need of the residents, the more staff required to meet these needs.

Administrators and direct care staff are supportive of a minimum staff ratio of one staff for every two residents with the residential program being limited to no more than five residents. They feel that the program should be co-educational and composed of individuals with similar needs and chronological age.

With the exception of a slight difference in staffing ratio, and program size, parents and concerned citizens reflected the same views as did the administrators and direct care staff. They indicated that a minimum staffing ratio should be one staff for every two to three residents and that the program should be limited to five to seven residents. Comments regarding co-educational residential programming indicated concerns related to adequate supervision. For the most part, the parents and concerned citizens surveyed supported co-educational living if the structure of the program was one which assured adequate resident privacy with regards to sleeping and bathing areas.

Comments of administrators and direct care staff indicate their support of co-educational residential
programming because it provides a more normalizing atmosphere. Such an atmosphere develops an understanding of similarities as well as differences in individuals and provides an opportunity for a cross range of activities.

3. Program Location

_institution vs. community._ The survey indicated that administrators, parents and direct care staff feel that residential programs should be located near the center of towns/cities and in suburban areas. All groups indicated that program location would also depend on the functioning and behavioral levels of the individuals served in the program.

Administrators justified their views by adding comments related to four areas.

1) Budget--In Franklin and Hampshire counties, current residential programs do not have adequate monies to provide the ideal living situation for residents. Most programs have been funded at the same level for the last three to five years. These programs are experiencing difficulty maintaining services and meeting rising costs.

2) Transportation--The Franklin/Hampshire area is faced with a transportation system which serves primarily the towns of Northampton, Amherst, and Greenfield. The outlying hill towns do not have adequate, regular transportation. Hence, services to these towns are limited.
Residing in one of these towns dictates that access to your own means of transportation be a major consideration.

Residential programs locating in these areas are faced with staff and resident transportation issues. Programs focusing on developing social skills and/or utilizing a shift staffing pattern might experience difficulty in coordinating activities and staff coverage.

3) Available housing—Rising real estate costs, mortgage rates, fuel and utility expenses has made it virtually impossible for sponsoring agencies to purchase and/or rent suitable houses for residential programs.

4) Rent inflation—Due to rising fuel and utility expenses, many available suitable and advantageously located dwellings are renting at prices well beyond the means of residential program residents.

With adequate transportation, suburban locations are viewed as the most desirable backup to being near the center of a city or town. The key to this location is transportation or access to public transportation. However, without suitable transportation, a suburban location could be no better than being confined to the grounds of a large institution.

Direct care staff and parents view residential programs located near the center of cities and towns from the perspective of convenience. It is less of a problem for both residents and staff if the program is located close to the
community services and agencies they will be dealing with. Both groups feel that the program and residents will use the resources of the community more if they do not have to go out of their way to do so.

Concerned citizens tend to support a suburban residential program location rather than near city and towns. Many commented that residential programs need space and a city or town location would not provide adequate space. Their comments inferred that mentally retarded individuals should be trained outside of the mainstream before coming into cities and towns. Near center town program locations should be reserved for those who are able to exhibit appropriate behavior and living skills.

Additionally, the survey indicated that an overwhelming majority of all five groups feel that residential programs should be located on secondary streets. The comments made regarding this issue reflected a move to cautiously integrate the mentally retarded into the community. The desire for the program to blend into rather than stand out from the community is the reasoning behind selecting secondary rather than main street locations.

The survey indicated that 36% of the concerned citizens were undecided on this issue. The author interprets this wavering attitude as one leaning towards support rather than rejection of the secondary street locations. This interpretation is based on the fact that a majority of concerned
citizens are in support of suburban residential locations and/or a duplex or two family type structure and these are usually found on secondary streets.

Physical structure. Those surveyed indicated that the most suitable structure for residential programs for the mentally retarded is a single family residence. Again, many individuals prefaced their selection by pointing out that the most suitable structure would depend on the functioning level of the residents served. However, a greater plurality of administrators, parents and concerned citizens supported the single family structure than did direct care staff.

Parents were more likely to respond favorably to single family residential structures because they view this type of program living structure conducive to family support and modeled after the family structure of parents (the staff) and children (the residents).

Concerned citizens viewed the single family structure as being most suitable because this program model appears easier to control. The living boundaries are more defined than they would be in an apartment complex with common living areas. Single family homes are usually constructed to hold a limited number of individuals comfortably. Therefore, the threat of a large program of more than five residents and the appropriate staff would be minimal.

Administrators support the single family structure as
the most suitable for residential programs because they are usually easier to rent and/or purchase for program use. Additionally, single family structures lend themselves to small, rather than large programming efforts and promote programming privacy. Staff and residents tend to have a more positive feeling for a single family dwelling. They view it more as their home, rather than their house.

Basically the direct care staff agreed with the single family structure being the most suitable for residential programming. However, they also heavily supported an apartment house, duplex type structure as an alternative. Their comments indicated that a structure of this type would have defined living areas with the possibility of positive modeling reinforcement of normal neighbors. Additionally, these type dwellings are usually located near the center of towns and cities close to public transportation lines and on secondary streets.

4. Program Responsibility

Two aspects of program responsibility surfacing, with overwhelming support, in this survey were supervision and training.

Parents view supervision and training in a connected yet separate way. They perceive training as preparing the resident for the risks encountered through increased community exposure and individual development. Supervision
is viewed as protecting the resident from the risk of hurting himself or being hurt in this process.

On the other hand, citizens view supervision and training with a slightly different focus. They tend to interpret supervision as the necessary shield of protection between the program and them. In other words, it is the responsibility of the staff to protect the citizen and community from the untrained and uncontrolled habits of the retarded. The staff is viewed as responsible for the positive and negative actions of the residents involved in the program.

Training is viewed as being connected with the appropriate behavioral and basic skills needed to function in the community. Individuals who do not exhibit the appropriate behavior need more supervision. The more inappropriate the behavior, the more protection citizens need in order to feel comfortable.

Direct care staff and administrators indicated that training was the most important responsibility component. However, they tend to view the need for increasing or decreasing this area as being dependent on the needs of the individual(s) involved in the program. The discrepancy regarding the amount of supervision and/or training an individual needs as seen by administrators and staff is often different than that of parents and citizens. Parents prefer supervision and training for the protection of the
individual. Citizens desire supervision and training of residents for the protection of the community and staff and administrators aspire to provide supervision and training for the development of the individual.

In meeting the needs of all, parents, citizens, direct care staff and administrators, there are risks involved. If supervision and training is geared to lay to rest the concerns of parents, the program will reflect an over-protective environment. In this type of environment the resident will learn to be more dependent on staff for support. Independent thinking and decision making will be stifled with staff direction and protection. Residents living in this type of sheltered situation will always require a sheltered situation and will not be prepared to live more independently.

If supervision and training is developed to calm citizen concerns, the program will reflect an environment which promotes separation from rather than integration with the community. The anxiety and uncertainty raised by supervision and training which restricts residents from the risks of community involvement is no better than institutional living. The residents learn that not only are they devalued in the eyes of the community but also in the eyes of the staff. The staff, in order to adequately supervise and train residents in this type of program, must be committed to protecting the values of the community. Hence,
the element of risk to residents is limited to the areas, services and individuals which are "safe" in terms of community standards. Supervision and training based on the needs of the residents promotes a program environment reflective of normal living. Inherent in developing this type of program, granting and fostering autonomy and independence, is the acceptance of a dignified measure of risk. It is essential to bear in mind that, while retarded individuals should not be set up to fail, they are categorically entitled to the right to fail. Failure can be a very positive learning experience and should be considered an integral facet of each individual's educational process. As human beings, mentally retarded people are citizens in the same social, political and constitutional sense as non-retarded people, and they are capable of growth and adaptation, even if profoundly retarded. Therefore, as adaptive human beings, they are deserving of challenges for growth, even if these challenges imply a measure of risk and discomfort. The element of risk is a necessary ingredient for human growth and development.

The development of a residential program incorporating a supervision and training mode characterizing normal living and built on the needs of individuals, as proposed by the direct care staff and administrators, requires an inordinate amount of communication. Individuals with information regarding the type and amount of supervision
and training provided for a resident, must make sure that this information is understood by and shared with those having the responsibility of implementing the supervision and training. Residents must be aware of the supervision and training structure. They must understand what staff members are responsible for and what is expected of them as residents in the program.

Parents and citizens, being involved with the program from a different perspective, must understand the program structure and the key staff members responsible for addressing their concerns. An informed residential staff assures that concerned citizens and parents will receive information consistent with program ideology, and residential service. The fewer people parents and citizens have to contact before their concerns are addressed, and the more people responding to parents and citizens in an expedient and uniform manner, the better they will feel about the program.

Last, and most important, everyone connected with this type of program structure must be committed to sharing the responsibility of the risk involved. This supportive program posture indicates that they are willing to let

Residents
Investigate
Society to gain
Knowledge.
Conclusion and Recommended Program Prototype

Perhaps the most important aspect in defining community residential programming involves the attitude of the people who assume the responsibility of providing these residential settings. No human being can be expected to grow and flourish in an atmosphere which is rejecting, stifling, or dehumanizing. Without a secure, comfortable home base, we can not realistically expect any mentally retarded person to become habilitated and to function as independently and productively as possible.

Providers of community residential programs must view the retarded as valuable human beings and as individuals. Mentally retarded persons must be treated with the respect due all human beings which is essential to their self-concept and dignity. According dignity means recognizing and honoring the individual's rights and his capacity for self-direction to the greatest extent possible. The difference between dignity and dehumanization can range from the obviously blatant to the very subtlest means of communicating an attitude.

The application of such terms as "self-concept, dignity and individual rights" to community residential programming is based more on good judgement and common sense than on formal doctrine or dogma. For example, residents must be allowed: privacy, use of telephone, uncensored mail,
personal possessions, freedom of movement, freedom to practice their religion, etc. To the greatest extent that an individual is capable of handling the responsibilities involved, he should be free to come and go from his home, have friends in, have contact with the opposite sex, and experience the normal role of a person his age, that is, being treated according to age, not limitation or handicap. An individual's ability to handle the responsibilities involved in all of these areas must be explored during his habilitation period.

Most persons, no matter how handicapped, tend to strive to achieve what is expected of them. In the past, negative expectations directed towards mentally retarded persons produced debilitation and dehumanization. If, however, the people in charge of residential programs expect the residents with whom they are involved to be trustworthy and do their best, their expectations are likely to become reality. Making residents feel trusted as hard-working honest individuals who are successful within their capabilities will give them incentive to be exactly that. Thus, a high expectation for residents should be the norm in all residential facilities regardless of the degree of structure or independence involved in them. Role expectancy is one of the most powerful means of modifying or changing behavior (Blatt, Biklen, Bogdan; 1977).

Mentally retarded persons must receive emotional
support in their residential program setting, and the guidance that they need to successfully progress toward community living.

In order for the mentally retarded to fit into society as inconspicuously as possible, and not stand out as being different, they must be exposed to a "normal" life style. Any residential program including mentally retarded people should establish a setting which provides a normal rhythm of the day: awakening, eating meals, working and sleeping at the same time that other people in society do these things. A normal rhythm of the week should also be established: leaving the place of residence to go to work, attend school, recreate, etc., as other people in society do. This implies a separation of function, as it is not normal in our society for people to live and work in the same setting or to spend all of their leisure time in the same facility in which they live or work. In other words, we should make available to the mentally retarded person the same patterns and conditions of everyday life which are as close as possible to the norms of society.

People who are mentally retarded must have good models of culturally normative adult life in society. The people providing residential programming for the retarded should not only be well-adjusted, good models themselves, but should also encourage contact with other non-handicapped people in the community. One of the best and easiest ways
to integrate residents into the community is through "peer models." Peer models are people who exhibit age-appropriate and culture-appropriate behavior for the residents to emulate. From a programmatic standpoint, a peer model might, for example, accompany one, two, or three residents, but no more, to a local bar. The residents might observe that their escort refrained from having more than two beers, that he didn't mix drinks, or that he was not loud or obnoxious. Of paramount importance, peer models have proven instrumental in assisting handicapped individuals to differentiate between good and bad influences which are typically encountered in daily living.

People assuming the responsibility of providing residential programming for mentally retarded individuals should also provide guidance and training to them. Residents should be expected and taught to assume responsibility by sharing family duties within their capacity. Such work in the home must not result in exploitation of the resident or cause him to feel that he is wanted only because of the work he does. Such involvement in the living skills will help the person to gain practical knowledge and will help prepare the person for greater independence.

People who are mentally retarded may further need guidance in the areas of grooming, hygiene, budgeting, socialization and resocialization. They should be encouraged to participate in constructive leisure time activities
and to make use of community resources to the extent that each individual is able.

A great deal of discretion must be used in determining which responsibilities and freedoms any one person can reasonably be expected to handle. Very realistically, some mentally retarded people are not prepared to cope with all of the responsibilities involved with individual rights and freedoms which have been outlined. Goals must be determined individually and realistically so that we do not set people up to fail. It is essential to bear in mind that, while handicapped individuals should not be set up to fail, they are categorically entitled to the right to fail. Failure can be a very positive learning experience and should be considered an integral facet of each individual's educational process. However, there should be a direct correlation between the amount of protection and/or shelter provided in a setting and the amount of guidance and/or training it provides. A person who is living in a sheltered situation will always require a sheltered situation and will not be prepared to live more independently (Goffman, 1961).

Inherent in the granting and fostering of autonomy and independence is the acceptance of a dignified measure of risk. In the past, mentally retarded persons' lives have been geared toward a sheltered and dependent existence. As human beings, retarded individuals are citizens in the same social, political, and constitutional sense as non-retarded
people, and they are capable of growth and adaptation, even if these challenges imply a measure of risk and discomfort. In determining the acceptable degree of risk for a retarded individual, again, good judgement and common sense will suffice.

In order to increase the mentally retarded's possibility of success in the community, residential programs must view themselves as Programs, not residences. The structure of the program must be one which seeks to develop and improve specific deficits within the framework of the total person. Such a program structure can be compared with that of our schools. Example: When a child enters school, the teacher seeks to develop skills that can be built upon. He/she does not attempt to provide the total educational experience. He/she sharpens the skills and behaviors which will enable those experiences to be understood and enjoyed. The expectations, job description, performance goals, etc. of the teacher are clear (reinforced by supervision, contract renewals and appropriate renumeration). The expectations, class responsibility, performance goals, etc. of the student are clear (reinforced by classroom praise, report cards, meetings with parents and promotion).

The teacher by promoting the student, signifies that he/she has reached the goals of that grade and is ready to learn the skills associated with the goals of the next grade.

We must begin to view community residences not only as
alternative living sites but also as alternative learning programs for the retarded. These living and learning sites must be programs geared to meet the needs of the residents.

**Program Prototype**

Preparing individuals to function as independently as possible at the level of their capabilities should be the focus of residential programs for the retarded. Inherent in this focus is the presupposition that those capable of progress will move on to a lesser restrictive living/learning environment. Programs should be structured to meet the needs of these individuals. They must develop, train and reinforce particular skills and provide the necessary impetus for movement to the next level of independence. Within this framework, a residential program living/learning site must:

1) Blend into its neighborhood. Each should conform to the norm within its own particular neighborhood.

2) Residential program living/learning sites should have no more residents than the surrounding community can readily and peaceably absorb. An overabundance of sites in any community, each one individually enabling mentally handicapped persons to live independently, would collectively pose the dilemma of having too many mentally retarded persons seeking too few jobs and apartments.

3) Residential program living/learning sites should be
located on or close to public transportation lines. By doing so, the retarded residents will have access to the larger community.

4) Within each living situation, furnishings should be adequate and comfortable and accommodations should ensure provisions for privacy as well as group activities.

In order to ensure smooth transition from one alternative to another, programs must assure that participants can exhibit a proficiency in basic skills related to that level.

Level I--Adjustment

Hygiene--goals
1) toilets self independently
2) bathes self independently
3) bathes whenever necessary
4) brushes teeth twice daily
5) cares for self during menstruation
6) shaves regularly--if decision made to shave
7) gets, uses and disposes of tissue independently

Health--goals
1) eats three balanced meals daily
2) exercises regularly
3) notifies staff when not feeling well
4) accepts drugs from responsible persons
5) has regular medical and dental care

Dressing--goals
1) dresses self independently
2) undresses self independently
3) recognizes own clothes and shoe size
4) regularly chooses clothes with matching colors, patterns and styles which fit properly
5) keeps clothes buttoned, snapped, and zippered
6) when weather changes, chooses appropriate clothing

Behavior—goals
1) does not exhibit dangerous behaviors to others or self
2) chooses appropriate outlets for anger
3) can control anger
4) shows respect for property of others
5) can interact appropriately with others

Communication—goals
1) pays attention to speaker
2) demonstrates adequate hearing
3) responds to simple physical commands
4) responds to simple request using objects
5) responds to simple request using colors
6) responds to simple request using numbers
7) responds to simple commands using prepositions (on, in, over, under)
8) responds to two step command
9) responds to three step command
10) responds to simple questions
11) verbally repeats directions
12) verbally summarizes information

Level II—Social Adjustment
Friendship/Interpersonal Skills—goals
1) refers to family members and other significant individuals by name
2) behaves courteously when with others
3) greets people in a socially acceptable manner
4) asks for help when needed
5) controls temper when angry
6) copes with rejection and/or criticism
7) behaves in appropriate manner in places requiring quiet
8) obeys rules and laws of home and society
9) listens without interrupting when people speak and responds appropriately
10) responds appropriately when the telephone or doorbell rings or someone knocks on the door
11) socializes at breaks and other appropriate times

Communication--Functional Reading, Speech--goals

1) verbalizes basic needs
2) identifies objects
3) uses simple sentences
4) gives information about past events
5) answers what, when, why, how questions
6) initiates conversation with peers
7) describes experiences in sequential order
8) names letters of alphabet
9) reads and uses functional signs in community (men, women, stop, telephone, exit, enter, etc.)
10) identifies words of warning
11) identifies and obeys traffic signs
12) identifies own name when he/she sees it written
13) identifies own phone number
14) writes/print name
15) reproduces numerals 0 to 9
16) writes/prints address
17) writes birthdate using numerals
18) writes telephone number
19) writes social security number
20) writes name of parents or guardians
Community Neighborhood--goals

1) knows name of neighbors
2) knows where the community neighborhood store is located
3) knows where the community neighborhood market is located
4) knows where the community neighborhood theatre is located
5) knows where the community neighborhood post office is located
6) knows where the community neighborhood hairdresser/barbershops are located
7) knows where the community neighborhood bank is located
8) knows where the community neighborhood church is located
9) knows where to find a policeman
10) knows where to find a fireman
11) knows where to find a doctor
12) can travel by bus, taxi
13) identifies appropriate public transportation vehicle by number and/or sign of destination
14) observes safety rules when crossing in traffic
15) observes safety rules when riding bike

Level III--Preparation for Independent Living

Food Preparation--goals

1) prepares snacks for self
2) prepares simple meal not requiring cooking
3) plan and cook complex meal for self (chicken, meat loaf, spaghetti)
4) identifies and uses kitchen utensils
5) identifies and uses major appliances
6) able to locate, read, understand directions for preparing food, operating appliances
7) if unsure of cooking procedures will ask for assistance  
8) cleans dishes, utensils and appliances used to prepare meals

**Clothing Care—goals**

1) does laundry before running out of clean clothes, towels and linens  
2) can prepare clothing for laundry—separates according to color  
3) can operate washer  
4) can operate dryer  
5) puts away clothing, including folding and putting it in drawers and hanging it on hangers

**House Cleaning—goals**

1) sweeps floors  
2) washes floors  
3) uses vacuum cleaner  
4) dusts  
5) cleans bathroom  
6) makes bed regularly  
7) cleans refrigerator and defrost freezer when needed  
8) cleans own bedroom and other rooms in the house

**Economic Management—goals**

1) identifies basic coins  
2) identifies money symbols  
3) understands value of coins  
4) state coin values equivalence  
5) counts change by referring to the face value of coins  
6) identifies bills  
7) makes change for $1.00 or less  
8) makes change for $5.00 or less
9) makes change for $10.00 or less
10) makes change for $20.00 or less
11) purchases items using coins
12) purchases items using currency
13) keeps money in safe place
14) recognizes own income
15) pays monthly bills
16) pays bills on time
17) puts money into bank for future use
18) uses savings account independently when making deposits and withdrawals

Work—goals

1) understands employment capability
2) understands where to look for employment
3) understands use of classified ads
4) expresses interest in particular job
5) understands employee responsibilities—reporting to work on time, cooperating with co-workers, dressing appropriately, etc.
6) can work steadily for extended periods of time without break
7) follows directions
8) performs routine tasks without supervisor

Level IV—Monitored Supportive/Independent Living

Agency Utilization—goals

1) can locate police department
2) can walk to police station independently
3) identifies police officer on sight
4) identifies police cruiser on sight
5) can locate police telephone number
6) understands when police assistance is necessary
7) can locate fire department
8) identifies firefighter on sight
9) identifies fire truck on sight
10) can locate fire department phone number
11) understands when firefighter assistance is necessary
12) can locate medical center/hospital
13) can locate medical center/hospital telephone number
14) understands when medical assistance is necessary

**Apartment Management—goals**

1) locks doors/windows when alone or about
2) keeps stairways, landings, floors, etc. dry and free of obstruction
3) uses stove and electrical appliances with caution and proper maintenance
4) safely uses and maintains decorations, extension cords, tools and miscellaneous items
5) can locate, has access to fire emergency exits
6) understands terms of lease—deposits, damages, notice, etc.
7) pays rent punctually
8) asks for rent receipt and keeps them in safe place
9) knows agents name, address, telephone number
10) cooperates with other tenants in upkeep or safety regulations
11) understands when his/her actions are distracting or disturbing
12) socializes with tenants or neighbors at appropriate times and with appropriate demeanor
13) asks other tenants for help at appropriate times
14) respects privacy of others

The above program focus should not be considered all inclusive. The author is suggesting that at a minimum each
program level should include these areas of training to insure that residents have received a skill core which can be expanded upon as goals are met.

Program staff may be selected and/or trained according to the program focus. Expectation of both staff and residents can be more clearly defined. Instead of being responsible for the development of the total person in relationship to the community, the staff can now be responsible for the development of specific basic skill areas in relationship to the total person. Improving the person results in increasing the possibility of success in the community. This should result in decreased frustration and increased productivity/progress in the specific program areas.

The program should not serve merely as a home with a family atmosphere where the residents receive recreation and learn how to use community resources. Each site should serve as an education training facility geared to train and develop the skills which will enable the retarded to function up to the level of his or her capability as independently as possible.

The attitude of the people who assume the responsibility of providing living/learning experiences is the most important aspect in defining a residential system. The staff should be trained in special education and/or possess the ability to impart the necessary skills to enable the retarded individual to make positive progress.
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<table>
<thead>
<tr>
<th>Degrees of Mental Retardation</th>
<th>Pre-School age 0-5 Maturation and Development</th>
<th>School age 6-20 Training and Education</th>
<th>Adult 21 and over Social and Vocational Adequacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Can develop social and communication skills; minimal retardation in sensori-motor areas; often not distinguished from normal until later age.</td>
<td>Can learn academic skills up to approximately sixth grade level by late teens. Can be guided toward social conformity. &quot;Educable&quot;</td>
<td>Can usually achieve social and vocational skills adequate to minimum self-support but may need guidance and assistance when under unusual social or economic stress.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Can talk or learn to communicate; poor social awareness; fair motor development; profits from training in self-help; can be managed with moderate supervision.</td>
<td>Can profit from training in social and occupational skills; unlikely to progress beyond second grade level in academic subjects; may learn to travel alone in familiar places.</td>
<td>May achieve self-maintenance in unskilled or semi-skilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress.</td>
</tr>
<tr>
<td>Severe</td>
<td>Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.</td>
<td>Can talk to learn to communicate; can be trained in elemental health habits; profits from systematic habit training.</td>
<td>May contribute partially to self-maintenance under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.</td>
</tr>
<tr>
<td>Profound</td>
<td>Gross retardation; minimal capacity for functioning in sensori-motor areas; needs nursing care.</td>
<td>Some motor development present; may respond to minimum or limited training in self-help.</td>
<td>Some motor and speech development; may achieve very limited self-care; needs nursing care.</td>
</tr>
</tbody>
</table>

APPENDIX B
APPENDIX C
1) The minimum educational requirement for residential staff members should be: (Check one)

___ (a) graduation from grade school
___ (b) graduation from junior high school
___ (c) graduation from high school
___ (d) graduation from college
___ (e) graduation plus professional training (special courses, workshops, etc.).

2) Residential staff members should be certified as special education teachers or in a related service area.

___ strongly approve  ___ approve
___ undecided          ___ disapprove
___ strongly disapprove

3) Prior to employment in a residential setting staff members should be experienced in working with retarded/special needs individuals.

___ strongly approve  ___ approve
___ undecided          ___ disapprove
___ strongly disapprove

4) The number of retarded/special needs individuals residing in the same residence should be: (Check one)

___ (a) unlimited
___ (b) limited to 9
___ (c) limited to 7
___ (d) limited to 5
___ (e) limited to 3
5) Residential programs for retarded/special needs individuals should be co-educational.

___ strongly approve  ___ approve
___ undecided           ___ disapprove
___ strongly disapprove

6) Residential programs for retarded/special needs individuals should be composed of individuals with similar needs, handicaps, and abilities.

___ strongly approve  ___ approve
___ undecided           ___ disapprove
___ strongly disapprove

7) Residential programs for retarded/special needs individuals should be composed of individuals with different needs, handicaps, and abilities.

___ strongly approve  ___ approve
___ undecided           ___ disapprove
___ strongly disapprove

8) Residential programs for retarded/special needs individuals should be composed of residents of different age grouping.

___ strongly approve  ___ approve
___ undecided           ___ disapprove
___ strongly disapprove

9) Residential programs for retarded/special needs individuals should be composed of residents of similar age grouping.

___ strongly approve  ___ approve
___ undecided           ___ disapprove
___ strongly disapprove
10) Retarded/special needs individuals should live in the community.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

11) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is near the center of towns/cities.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

12) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is in a suburban area.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

13) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is in a rural area.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

14) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is on the grounds of an institution for the retarded.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove
15) The most suitable structure for residential programs for the retarded/special needs individuals is within apartment complexes, i.e. Brandywine, Meadowbrook, Leyden Woods.

___ strongly approve        ___ approve
___ undecided               ___ disapprove
___ strongly disapprove

16) The most suitable structure for residential programs for the retarded/special needs individuals is an apartment house, i.e. duplex or two family type structure.

___ strongly approve        ___ approve
___ undecided               ___ disapprove
___ strongly disapprove

17) The most suitable structure for residential programs for the retarded/special needs individuals is a single family residence.

___ strongly approve        ___ approve
___ undecided               ___ disapprove
___ strongly disapprove

18) The most suitable structure for residential programs for the retarded/special needs individuals is an institutional complex, i.e. nursing homes, hospitals, intermediate care facilities, etc.

___ strongly approve        ___ approve
___ undecided               ___ disapprove
___ strongly disapprove

19) Residential programs for the retarded/special needs individuals should be located on main streets.

___ strongly approve        ___ approve
___ undecided               ___ disapprove
___ strongly disapprove
20) Residential programs for the retarded/special needs individuals should be located on secondary streets.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

21) Retarded/special needs individuals should receive residential programming primarily within an institutional setting.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

22) Retarded/special needs individuals should receive residential programming primarily within community based settings.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

23) Supervision of residents should be the most important responsibility of residential staff members.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

24) Training/tutoring residents should be the most important responsibility of residential staff members.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove
25) The major responsibility for transportation for leisure time activities in residential programs rest with the: (Check one)

  ___ (a) parents/guardians of residents  
  ___ (b) local school system  
  ___ (c) Department of Mental Health  
  ___ (d) residential program staff  
  ___ (e) existing community transportation system

26) Residential programs should provide planned leisure time activities for its residents.

  ___ strongly approve  ___ approve  
  ___ undecided  ___ disapprove  
  ___ strongly disapprove

27) In a residential program where the residents have recently come from an institution, the most important preparation focus should be: (Check one)

  ___ (a) preparation for independent living (work, banking, budgeting, house cleaning, etc.)  
  ___ (b) functional academics (basic reading, writing, math, etc.)  
  ___ (c) community awareness (knows neighbors, store location, post office, church, etc.)  
  ___ (d) interpersonal skill building (control of temper, courtesy to others, obeying rules and laws, etc.)  
  ___ (e) self help skills (hygiene care, dressing, food preparation, communication, etc.)

28) Residents who consistently exhibit unacceptable behavior should be returned to the institution.

  ___ strongly approve  ___ approve  
  ___ undecided  ___ disapprove  
  ___ strongly disapprove
29) Residents who consistently exhibit unacceptable behavior should be confined to the residence and given corporal punishment (whipping, spanking, etc.)

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove

30) Residents who consistently exhibit unacceptable behavior should be confined to the residence.

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove

31) Residents who consistently exhibit unacceptable behavior should be reprimanded.

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove

32) Residents who consistently exhibit unacceptable behavior should receive intensive daily training.

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove

33) Every residential program for retarded/special needs individuals should provide sex education information.

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove
34) Every residential program for retarded/special needs individuals should have a minimum staff ratio of:
(Check one)

___ (a) 1 staff for every resident
___ (b) 1 staff for every 2 residents
___ (c) 1 staff for every 3 residents
___ (d) 1 staff for every 4 residents
___ (e) 1 staff for every 5 residents

35) The most important services to be provided in a residential program for retarded/special needs individuals are:

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

36) I would support a residential program locating in my neighborhood if:

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________
APPENDIX D
To Whom It May Concern:

The Franklin/Hampshire Area Office supports Mr. Hutchings' proposed attitudinal survey study pertaining to residential services for the mentally retarded in our area. The information gained from this study will:

1) Provide valuable planning data for the Franklin/Hampshire service area.

2) Assist the Area Office and vendors in appraising the perception of quality and community acceptance of current residential programs.

3) Provide an alternative mechanism for citizen participation in planning of residential services for the retarded of Franklin/Hampshire area.

4) Clarify residential attitudinal differences of program administrators, direct care staff, citizens and parents of mentally retarded individuals.

5) Provide information from which a mental retardation residential prototype can be developed.

I am requesting that you and/or your agency cooperate in helping Mr. Hutchings complete this study as expeditiously as possible. Thank you.

Sincerely,

Hal Gibber
Area Director

HJG:jgl
APPENDIX E
Mr. David Scanlin, Director  
Community Homes for Children  
256 State Street  
Northampton, Massachusetts 01060

Dear Mr. Scanlin:

During my tenure as Franklin/Hampshire coordinator of mental retardation services, I became aware of the differing attitudes and factionalism regarding the residential prototypes planned for the mentally retarded served in our area. Differing attitudes on the part of administrators of residential programs, direct care staff of residential programs, parents of retarded individuals, and citizens have generated conflicting planning information for the Franklin/Hampshire Area Office.

As part of my doctoral studies at the University of Massachusetts, I am concentrating on developing a residential prototype(s) which addresses the concerns of the aforementioned groups. In an attempt to understand the concerns and amass information relative to the development of meaningful residential programming, I have developed an attitudinal survey instrument. This will be used to survey:

1) Administrators of residential programs - those individuals having responsibility for residential program/budget development, program policy, staff selection, supervision and evaluation.

2) Direct care staff - those individuals assigned to residential programs having responsibility for the direct training and/or supervision of the mentally retarded residing there.

3) Concerned citizens - members of the community who are not parents of a mentally retarded individual.

4) Parents/guardians of mentally retarded individuals.

I am requesting your assistance in gathering information. On the form provided please indicate the number of administrators and direct staff meeting the requirements outlined in groups 1 and 2 above and return to me as soon as possible. Upon receipt of this information I will forward the number of survey instruments requested together with
stamped envelopes for their return.

If you have any questions or need further information please feel free to contact me at (413) 256-8895.

I appreciate your expending time and effort in assisting me in the study. All results of the study will be made available to the participants. Thank you.

Sincerely,

Harold M. Hutchings

HMH: jr

Please detach and return in the enclosed stamped self addressed enveloped:

Contact person__________________________________________

Telephone number________________________________________

Agency____________________________________________________

Address___________________________________________________

Number of administrator surveys needed ___

Number of direct care staff surveys needed ___
Mr. Roger Brunelle, President  
Riverside Industries, Inc.  
One Cottage Street  
Easthampton, Massachusetts 01027

Dear Mr. Brunelle:  

During my tenure as Franklin/Hampshire coordinator of mental retardation services, I became aware of the differing attitudes and factionalism regarding the residential prototypes planned for the mentally retarded served in our area. Differing attitudes on the part of administrators of residential programs, direct care staff of residential programs, parents of retarded individuals, and citizens have generated conflicting planning information for the Franklin/Hampshire Area Office.

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Sincerely,

Harold M. Hutchings

HMH: jr

Please detach and return in the enclosed stamped self addressed envelope:

-------------------------------------------------------------
Contact person
-------------------------------------------------------------
Telephone number
-------------------------------------------------------------
Agency
-------------------------------------------------------------
Address
-------------------------------------------------------------
Number of administrator surveys needed ___
Number of direct care staff surveys needed ___
Mr. Richard Geffin, Director
Hampshire County Association
for Retarded Citizens
12 Main Street
Northampton, Massachusetts 01060

Dear Mr. Geffin:

During my tenure as Franklin/Hampshire coordinator of mental retardation services, I became aware of the differing attitudes and factionalism regarding the residential prototypes planned for the mentally retarded served in our area. Differing attitudes on the part of administrators of residential programs, direct care staff of residential programs, parents of retarded individuals, and citizens have generated conflicting planning information for the Franklin/Hampshire Area Office.

As part of my doctoral studies at the University of Massachusetts, I am concentrating on developing a residential prototype(s) which addresses the concerns of the aforementioned groups. In an attempt to understand the concerns and amass information relative to the development of meaningful residential programming, I have developed an attitudinal survey instrument. This will be used to survey:

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2) Direct care staff - those individuals assigned to residential programs having responsibility for the direct training and/or supervision of the mentally retarded residing there.

3) Concerned citizens - members of the community who are not parents of a mentally retarded individual.

4) Parents/guardians of mentally retarded individuals.

I am requesting your assistance in gathering information from parents/guardians of mentally retarded individuals. I would appreciate a copy of your parent/guardian membership list so that I can include them in my survey. Enclosed is a
stamped self addressed envelope for your convenience.

If you have any questions or need further information please feel free to contact me at (413) 256-8895.

I appreciate your expending time and effort in assisting me with this study. All results of the study will be made available to the participants. Thank you.

Sincerely,

Harold M. Hutchings

HMH:jr
Mr. Ed Porter, Director
Franklin County Association
for Retarded Citizens
213 Silver Street
Greenfield, Massachusetts 01301

Dear Mr. Porter:

During my tenure as Franklin/Hampshire coordinator of mental retardation services, I became aware of the differing attitudes and factionalism regarding the residential prototypes planned for the mentally retarded served in our area. Differing attitudes on the part of administrators of residential programs, direct care staff of residential programs, parents of retarded individuals, and citizens have generated conflicting planning information for the Franklin/Hampshire Area Office.

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4) Parents/guardians of mentally retarded individuals.

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stamped self addressed envelope for your convenience.

If you have any questions or need further information please feel free to contact me at (413) 256-8895.

I appreciate your expending time and effort in assisting me with this study. All results of the study will be made available to the participants. Thank you.

Sincerely,

Harold M. Hutchings

HMH: jr
Ms. Jane Moser, President
Franklin/Hampshire Mental Health/
Mental Retardation Area Board
275 Elm Street
Northampton, Massachusetts 01060

Dear Ms. Moser:

During my tenure as Franklin/Hampshire coordinator of mental retardation services, I became aware of the differing attitudes and factionalism regarding the residential prototypes planned for the mentally retarded served in our area. Differing attitudes on the part of administrators of residential programs, direct care staff of residential programs, parents of retarded individuals, and citizens have generated conflicting planning information for the Franklin/Hampshire Area Office.

As part of my doctoral studies at the University of Massachusetts, I am concentrating on developing a residential prototype(s) which addresses the concerns of the aforementioned groups. In an attempt to understand the concerns and amass information relative to the development of meaningful residential programming, I have developed an attitudinal survey instrument. This will be used to survey:

1) Administrators of residential programs- those individuals having responsibility for residential program/budget development, program policy, staff selection, supervision and evaluation.

2) Direct care staff - those individuals assigned to residential programs having responsibility for the direct training and/or supervision of the mentally retarded residing there.

3) Concerned citizens - members of the community who are not parents of a mentally retarded individual.

4) Parents/guardians of mentally retarded individuals.

I am requesting your assistance in gathering information from concerned citizens serving on the Area Board who are not parents or guardians of mentally retarded individuals. I would like to include these individuals in the survey and would appreciate board sanction to do so.
Upon receipt of board approval I will forward the survey instrument to those board members meeting the aforementioned criteria.

If you have any questions or need further information please feel free to contact me at (413) 256-8895.

I appreciate your expending time and effort in assisting me with the study. All results of the study will be made available to the participants. Thank you.

Sincerely,

Harold M. Hutchings

HMH:jr
Residential Staff Qualifications

1) The minimum educational requirement for residential staff members should be: (Check one)
   ___ (a) graduation from grade school
   ___ (b) graduation from junior high school
   ___ (c) graduation from high school
   ___ (d) graduation from college
   ___ (e) graduation plus professional training (special courses, workshops, etc.).

2) Residential staff members should be certified as special education teachers or in a related service area.
   ___ strongly approve        ___ approve
   ___ undecided              ___ disapprove
   ___ strongly disapprove

3) Prior to employment in a residential setting staff members should be experienced in working with retarded/special needs individuals.
   ___ strongly approve        ___ approve
   ___ undecided              ___ disapprove
   ___ strongly disapprove
Program Size/Makeup

4) The number of retarded/special needs individuals residing in the same residence should be: (Check one)

___ (a) unlimited
___ (b) limited to 9
___ (c) limited to 7
___ (d) limited to 5
___ (e) limited to 3

5) Residential programs for retarded/special needs individuals should be co-educational.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

6) Residential programs for retarded/special needs individuals should be composed of individuals with similar needs, handicaps, and abilities.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove

7) Residential programs for retarded/special needs individuals should be composed of individuals with different needs, handicaps, and abilities.

___ strongly approve  ___ approve
___ undecided  ___ disapprove
___ strongly disapprove
Program Size/Makeup (continued)

8) Residential programs for retarded/special needs individuals should be composed of residents of different age grouping.

___ strongly approve    ___ approve
___ undecided           ___ disapprove
___ strongly disapprove

9) Residential programs for retarded/special needs individuals should be composed of residents of similar age grouping.

___ strongly approve    ___ approve
___ undecided           ___ disapprove
___ strongly disapprove

34) Every residential program for retarded/special needs individuals should have a minimum staff ration of: (Check one)

___ (a) 1 staff for every resident
___ (b) 1 staff for every 2 residents
___ (c) 1 staff for every 3 residents
___ (d) 1 staff for every 4 residents
___ (e) 1 staff for every 5 residents
Program Location

10) Retarded/special needs individuals should live in the community.
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

11) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is near the center of towns/cities.
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

12) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is in a suburban area.
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

13) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is in a rural area.
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

14) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is on the grounds of an institution for the retarded.
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove
Program Location (continued)

15) The most suitable structure for residential programs for the retarded/special needs individuals is within apartment complexes, i.e. Brandywine, Meadowbrook, Leyden Woods.

___ strongly approve  ___ approve
___ undecided        ___ disapprove
___ strongly disapprove

16) The most suitable structure for residential programs for the retarded/special needs individuals is an apartment house, i.e. duplex or two family type structure.

___ strongly approve  ___ approve
___ undecided        ___ disapprove
___ strongly disapprove

17) The most suitable structure for residential programs for the retarded/special needs individuals is a single family residence.

___ strongly approve  ___ approve
___ undecided        ___ disapprove
___ strongly disapprove

18) The most suitable structure for residential programs for the retarded/special needs individuals is an institutional complex, i.e. nursing homes, hospitals, intermediate care facilities, etc.

___ strongly approve  ___ approve
___ undecided        ___ disapprove
___ strongly disapprove
Program Location (continued)

19) Residential programs for the retarded/special needs individuals should be located on main streets.
   
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

20) Residential programs for the retarded/special needs individuals should be located on secondary streets.
   
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

21) Retarded/special needs individuals should receive residential programming primarily within an institutional setting.
   
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove

22) Retarded/special needs individuals should receive residential programming primarily within community based settings.
   
   ___ strongly approve ___ approve
   ___ undecided ___ disapprove
   ___ strongly disapprove
Program Responsibility

23) Supervision of residents should be the most important responsibility of residential staff members.
   ___ strongly approve   ___ approve
   ___ undecided         ___ disapprove
   ___ strongly disapprove

24) Training/tutoring residents should be the most important responsibility of residential staff members.
   ___ strongly approve   ___ approve
   ___ undecided         ___ disapprove
   ___ strongly disapprove

25) The major responsibility for transportation for leisure time activities in residential programs rest with the:
    (Check one)
    ___ (a) parents/guardians of residents
    ___ (b) local school system
    ___ (c) Department of Mental Health
    ___ (d) residential program staff
    ___ (e) existing community transportation system

26) Residential programs should provide planned leisure time activities for its residents.
   ___ strongly approve   ___ approve
   ___ undecided         ___ disapprove
   ___ strongly disapprove
Program Responsibility (continued)

27) In a residential program where the residents have recently come from an institution, the most important preparation focus should be: (Check one)

___ (a) preparation for independent living (work, banking, budgeting, house cleaning, etc.)
___ (b) functional academics (basic reading, writing, math, etc.)
___ (c) community awareness (knows neighbors, store location, post office, church, etc.)
___ (d) interpersonal skill building (control of temper, courtesy to others, obeying rules and laws, etc.)
___ (e) self help skills (hygiene care, dressing, food preparation, communication, etc.)

28) Residents who consistently exhibit unacceptable behavior should be returned to the institution.

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove

29) Residents who consistently exhibit unacceptable behavior should be confined to the residence and given corporal punishment (whipping, spanking, etc.)

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove

30) Residents who consistently exhibit unacceptable behavior should be confined to the residence.

___ strongly approve ___ approve
___ undecided ___ disapprove
___ strongly disapprove
Program Responsibility (continued)

31) Residents who consistently exhibit unacceptable behavior should be reprimanded.

___ strongly approve       ___ approve
___ undecided              ___ disapprove
___ strongly disapprove

32) Residents who consistently exhibit unacceptable behavior should receive intensive daily training.

___ strongly approve       ___ approve
___ undecided              ___ disapprove
___ strongly disapprove

33) Every residential program for retarded/special needs individuals should provide sex education information.

___ strongly approve       ___ approve
___ undecided              ___ disapprove
___ strongly disapprove

35) The most important services to be provided in a residential program for retarded/special needs individuals are

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

36) I would support a residential program locating in my neighborhood if

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
APPENDIX G
MR RESIDENTIAL PROTOTYPE SURVEY SUMMARY

1) The minimum educational requirement for residential staff members should be: (Check one)

1  (a) graduation from high school

1  (b) graduation from junior high school

56 (c) graduation from high school

26 (d) graduation from college

51 (e) graduation plus professional training (special courses, workshops, etc.)

14*

2) Residential staff members should be certified as special education teachers or in a related service area.

33 strongly approve  50 approve

18 undecided  37 disapprove

7 strongly disapprove  4*

3) Prior to employment in a residential setting staff members should be experienced in working with retarded/special needs individuals.

54 strongly approve  74 approve

undecided  16 disapprove

1 strongly disapprove  4*

4) The number of retarded/special needs individuals residing in the same residence should be: (Check one)

3  (a) unlimited  12*

20  (b) limited to 9

29  (c) limited to 7

66  (d) limited to 5

14  (e) limited to 3
5) Residential programs for retarded/special needs individuals should be co-educational.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>72</td>
<td>22</td>
<td>1</td>
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</table>

6) Residential programs for retarded/special needs individuals should be composed of individuals with similar needs, handicaps, and abilities.

<table>
<thead>
<tr>
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<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>64</td>
<td>17</td>
<td>2</td>
</tr>
</tbody>
</table>

7) Residential programs for retarded/special needs individuals should be composed of individuals with different needs, handicaps, and abilities.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>33</td>
<td>29</td>
<td>8</td>
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</tbody>
</table>

8) Residential programs for retarded/special needs individuals should be composed of residents of different age grouping.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>53</td>
<td>22</td>
<td>5</td>
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</tbody>
</table>

9) Residential programs for retarded/special needs individuals should be composed of residents of similar age grouping.

<table>
<thead>
<tr>
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<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>66</td>
<td>26</td>
<td>2</td>
</tr>
</tbody>
</table>
10) Retarded/special needs individuals should live in the community.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Strongly Disapprove</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>83</td>
<td>44</td>
<td>11</td>
<td>2</td>
<td>3*</td>
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</tbody>
</table>

11) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is near the center of towns/cities.

<table>
<thead>
<tr>
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<th>Approve</th>
<th>Undecided</th>
<th>Strongly Disapprove</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>53</td>
<td>22</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

12) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is in a suburban area.

<table>
<thead>
<tr>
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<th>Approve</th>
<th>Undecided</th>
<th>Strongly Disapprove</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>60</td>
<td>27</td>
<td>6</td>
<td>10*</td>
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</tbody>
</table>

13) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is in a rural area.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Strongly Disapprove</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>30</td>
<td>41</td>
<td>7</td>
<td>14*</td>
</tr>
</tbody>
</table>

14) Given adequate transportation, the most suitable location for residential programs for retarded/special needs individuals is on the grounds of an institution for the retarded.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Strongly Disapprove</th>
<th>Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>10</td>
<td>66</td>
<td>9*</td>
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</tbody>
</table>
15) The most suitable structure for residential programs for the retarded/special needs individuals is within apartment complexes, i.e. Brandywine, Meadowbrook, Leyden Woods.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
<th>Strongly Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>23</td>
<td>34</td>
<td>61</td>
<td>12</td>
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</tbody>
</table>

16) The most suitable structure for residential programs for the retarded/special needs individuals is an apartment house, i.e. duplex or two family type structure.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
<th>Strongly Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>64</td>
<td>27</td>
<td>36</td>
<td>1</td>
</tr>
</tbody>
</table>

17) The most suitable structure for residential programs for the retarded/special needs individuals is a single family residence.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
<th>Strongly Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>77</td>
<td>20</td>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>

18) The most suitable structure for residential programs for the retarded/special needs individuals is an institutional complex, i.e. nursing homes, hospitals, intermediate care facilities, etc.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
<th>Strongly Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>16</td>
<td>15</td>
<td>52</td>
<td>50</td>
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</tbody>
</table>

19) Residential programs for the retarded/special needs individuals should be located on main streets.

<table>
<thead>
<tr>
<th>Strongly Approve</th>
<th>Approve</th>
<th>Undecided</th>
<th>Disapprove</th>
<th>Strongly Disapprove</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>24</td>
<td>33</td>
<td>58</td>
<td>14</td>
</tr>
</tbody>
</table>

20) Residential programs for the retarded/special needs individuals should be located on secondary streets.

13 strongly approve
25 undecided
4 strongly disapprove

80 approve
6 disapprove
21*

21) Retarded/special needs individuals should receive residential programming primarily within an institutional setting.

3 strongly approve
7 undecided
52 strongly disapprove

9 approve
71 disapprove

22) Retarded/special needs individuals should receive residential programming primarily within community based settings.

59 strongly approve
10 undecided
2 strongly disapprove

70 approve
4 disapprove
4*

23) Supervision of residents should be the most important responsibility of residential staff members.

43 strongly approve
15 undecided
2 strongly disapprove

48 approve
29 disapprove
12*

24) Training/tutoring residents should be the most important responsibility of residential staff members.

51 strongly approve
13 undecided
1 strongly disapprove

56 approve
17 disapprove
11*
25) The major responsibility for transportation for leisure time activities in residential programs rest with the: (Check one)

13  (a) parents/guardians of residents

3   (b) local school system

17  (c) Department of Mental Health

57  (d) residential program staff

27  (e) existing community transportation system

32*

26) Residential programs should provide planned leisure time activities for its residents.

48  strongly approve

11  undecided

15  strongly disapprove

27  strongly disapprove

6*

27) In a residential program where the residents have recently come from an institution, the most important preparation focus should be: (Check one)

13  (a) preparation for independent living (work, banking, budgeting, house cleaning, etc.)

5   (b) functional academics (basic reading, writing, math, etc.)

11  (c) community awareness (knows neighbors, store location, post office, church, etc.)

27  (d) interpersonal skill building (control of temper, courtesy to others, obeying rules and laws, etc.)

63  (e) self help skills (hygiene care, dressing, food preparation, communication, etc.)

30*
28) Residents who consistently exhibit unacceptable behavior should be returned to the institution.

10 strongly approve
31 undecided
29 strongly disapprove

29) Residents who consistently exhibit unacceptable behavior should be confined to the residence and given corporeal punishment (whipping, spanking, etc.)

2 strongly approve
6 undecided
90 strongly disapprove

30) Residents who consistently exhibit unacceptable behavior should be confined to the residence.

18 strongly approve
22 undecided
19 strongly disapprove

31) Residents who consistently exhibit unacceptable behavior should be reprimanded.

28 strongly approve
14 undecided

32) Residents who consistently exhibit unacceptable behavior should receive intensive daily training.

62 strongly approve
6 undecided
2 strongly disapprove
33) Every residential program for retarded/special needs individuals should provide sex education information.

59 strongly approve 63 approve
15 undecided 5 disapprove
1 strongly disapprove 6*

34) Every residential program for retarded/special needs individuals should have a minimum staff ratio of: (Check one)

7 (a) 1 staff for every resident
44 (b) 1 staff for every 2 residents
48 (c) 1 staff for every 3 residents
20 (d) 1 staff for every 4 residents
3 (e) 1 staff for every 5 residents

27*

35) The most important services to be provided in a residential program for retarded/special needs individuals are:

Basic skills - 25
Training appropriate behaviors - 52
Supervision - 21
Other - 26

25**

36) I would support a residential program locating in my neighborhood if

Adequate supervision - 60
Training - 6
Funding - 4
Other - 20

59**

* Number indicating their concerns by writing a comment and not selecting the available choices.
**Number failing to answer.