Profiles of Housing Alternatives Available to Manitoba's Disabled

by Jonathan P. Gunn
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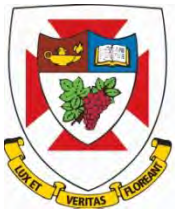
The Institute of Urban Studies



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PROFILES OF HOUSING ALTERNATIVES AVAILABLE TO MANITOBA'S DISABLED
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Jonathan P. Gunn

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Finally, I wish to express my gratitude to the many individuals who contributed their time and valuable information to this project.

Jonathan P. Gunn

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1.0 INTRODUCTION

In this report a profile is constructed of all housing types revealed by the research*for each of the five major groupings of disabled persons within the province's general population. These five groupings are: the physically disabled (in terms of limb impairment), the mentally retarded, persons with a psychiatric disability or the 'mentally ill', the visually impaired, and the hearing impaired. In these profiles the focus will be placed on the following factors concerning each housing type or setting: the nature of the residential form; the services the occupants receive; if available, the number of persons in the province housed in this manner; and the relative level of normalization which the setting in question allows its disabled occupants.

Concerning the last factor, 'normalization' is used in this discussion in the manner in which it was described in the first report of this series. It has two components, 'independence' and'integration'. Briefly, independence refers to a significant degree of control over one's own affairs or of self-determination. Integration refers to both the physical integration, in terms of location, of one's place of residence within the community and social integration--meaningful contact and interplay with other sectors of the community. Any assessment of relative normalization of a housing type must be viewed as being subjective. The assessments below,however, are based on contacts with numerous 'experts' in the field, available background information and the knowledge the author has developed on this theme. The assessed level of normalization of a housing type provides the organizational framework for the discussion in this report (see Table 1).

The list of housing types by disabled grouping cited in this chapter is extensive. Unfortunately a certain degree of confusion appears to exist concerning the terminology which the sources for this discussion (provincial officials, agencies serving/representing disabled groups, disabled consumer advocate groups) use for the various settings. As well, many of the sources

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*The original research upon which this report is based was conducted for a 1982 CMHC - sponsored study. This report is the second in a series of three reports produced from the author's 1982 study. The first report, Housing for the Disabled in Manitoba, provides a summary of the major findings and conclusions of the original study. The third report, Housing Manitoba's Disabled: Case Studies of Representative Housing Types, provides a detailed case analysis of a few settings which are representative of the housing forms available to the province's disabled.

Table 1

Continuum Of Housing Alternatives

Most Normalized Setting

Self-Contained residence
- : physically disabled
- : mentally retarded
- : mentally ill
- : visually impaired
- : hearing impaired

Independent living with support
- : physically disabled (Fokus)
- : mentally retarded (Supported Apartments)
- : mentally ill (Supervised Apartments)
- : hearing impaired (Independent Apartments - Kiwanis Centre)

Room and board
- : visually impaired

Independent group living
- : mentally ill (I.G.L.P.)

Supervised group living
- : mentally retarded (Community Residences/Group Homes; Group Foster Homes)
- : mentally ill (Sara Riel)

Transitional setting
- : physically disabled (Ten Ten Sinclair)
- : mentally ill (Parkland Villa)
- : visually impaired (Transition Apartments)

Residential care
- : mentally ill (Residential Care Homes)
- : visually impaired (Hostels)
- : hearing impaired (Community Residence - Kiwanis Centre)

Nursing homes/personal care homes
- : physically disabled
- : mentally retarded
- : mentally ill
- : visually impaired
- : hearing impaired

Large treatment and/or training centres
- : physically disabled (Rehabilitation Hospital; hospital wards)
- : mentally retarded (School for Retardates; Pelican Lake; St. Amant)
- : mentally ill (S.M.H.C.; B.M.H.C.; psychiatric wards)
- : visually impaired (School for Retardates; acute care wards)
- : hearing impaired (School for Retardates; S.M.H.C.)

Least Normalized Setting

have only sketchy information, if any, on settings in which they do not have direct involvement. Thus, an exhaustive compilation of housing types for Manitoba's disabled will have to await the emergence of a more well-rounded and complete perspective on provision among the relevant actors. Nevertheless, by piecing together the different and sometimes conflicting information from the various sources contacted, a fairly comprehensive picture of the existing housing situation for Manitoba's disabled population can be presented.

2.0 PHYSICALLY DISABLED

2.1 Self-contained residence

a) Description

The indication is that the great majority of persons with physical impairments are residing in some form of owned or rented self-contained, single family dwelling. These persons may be living alone or residing with a spouse, family, or a friend. Physically disabled persons who are so housed may be found throughout the province. The degree of physical impairment among this population would range widely, although a great many would have relatively limited impairment.

Some of these self-contained residences have incorporated within them certain physical adaptations to facilitate day-to-day life for the disabled resident (e.g.alterations which make the home wheelchair accessible). However, the indication is that there are relatively few self-contained residences in Manitoba in which adaptations geared to the disabled have been incorporated, particularly of the type which provides accessibility to persons in wheelchairs. Of course, for the many physically disabled persons so housed who have relatively minor physical impairment, the need for such adaptations to the home is far less pressing than for the more severely disabled.

b) Services

The majority of physically disabled persons housed in this manner either do not require special aid because of the limited nature of their disability and/or architectural adaptations to their home or because they receive any needed assistance from co-habitating family members. However, persons requiring additional assistance or living alone and in need of some physical aid can get this assistance through the provincial Home Care program (Office of Continuing Care).

Briefly, based on particular need, Home Care can provide one or a combination of services including nursing, therapy, social work, homemaking and the provision of medical supplies or equipment. It can also arrange for a variety of volunteer services. The focus of the program is to allow persons to remain in their own home who have

disabilities such that they cannot carry out certain physical functions of day-to-day living. The Home Care program is province-wide in scope. A person is eligible if he/she cannot manage his/her own care, if family or friends are unable to provide the necessary type or amount of care, and if he/she has been assessed as requiring services and the determination is made that his/her needs can adequately be met at home. In an average month about 11,000 Manitobans are receiving Home Care services. However, the great majority of these persons are recipients because of the overall debilitations of old age rather than because of specific physical disabilities. In fact, the indication is that the disabled under 64 would make up less than 20% of this total.

c) Population

As noted above, it would seem that most physically disabled persons reside in some form of self-contained residence. However, it is apparent that no accurate data are presently available on how many physically disabled persons in the province are so housed, or for that matter, what the overall size of Manitoba's physically disabled population is.

d) Relative level of normalization

For the most part this population can probably be viewed as enjoying a very independent lifestyle (i.e. a maximum amount of personal control over one's day-to-day affairs). The ability of these persons to live in a self-contained residence would generally reflect a very limited level of dependence on other persons in their daily lives. The exceptions to this generalization would primarily be those individuals who reside with family members, are heavily dependent on the assistance and support of these relatives and who probably would be housed in some other manner if not for the support role the relatives play in their lives.

In terms of integration, such housing in most cases ensures physical integration of the disabled person into the community. This in turn greatly enhances the opportunity for meaningful social integration. Individual circumstances such as the degree of dependence on relatives would determine, to a great extent, how much social interaction with others in the community actually occurs.

2.2 Apartment living with support

a) Description

Existing examples of housing of this type in Manitoba for the physically disabled are the Fokus I and Fokus II projects. A third Fokus project is in the planning stages. Fokus I and II are located in Winnipeg (at 375 Assiniboine and 15 Kennedy respectively) and the new project is also planned for Winnipeg. The goal of Fokus is to provide private individual housing to the severely physically disabled in an integrated apartment setting (non-disabled persons also live in the block) as well as to provide shared support services which allow the disabled residents to live as independently as possible. The suites for the disabled residents have been architecturally modified to make them accessible.

b) Services

Persons living in Fokus units are provided with on-site personal care from attendants and homemaking services. The attendant staff are employees of Ten Ten Sinclair (see 2.3). These support services are provided through the provincial Home Care Program.

c) Population

This new and innovative form of housing is available to very few persons at present and, as noted above, only in Winnipeg. About 24 persons were living in the two existing Fokus projects in 1982. When completed, the proposed third Fokus project would house an additional 10-15 disabled persons.

d) Relative level of normalization

A great deal of responsibility for one's own affairs (i.e. personal independence) is demanded in such private accommodation. Although residents are dependent on the Home Care services provided for certain needs, these services can be viewed as actually promoting greater personal independence because they allow the persons involved private accommodation rather than the group or institutional arrangement which would undoubtedly be necessary for them if such services were not available.

Concerning integration, the Fokus projects are physically integrated into 'main stream' apartment blocks. This physical integration enhances greatly the opportunity for meaningful social integration of the Fokus tenants into the community at large.

2.3 Transitional setting

a) Description

For the physically disabled, the only example of such a setting in Manitoba would appear to be Ten Ten Sinclair. Located in north Winnipeg, the mandate of Ten Ten Sinclair is to provide interim housing for physically disabled adults. The objective is to give the tenants an opportunity to gain residential living experience; to achieve physical independence and exposure to community integration; and to develop personal and homemaking skills and awareness of relevant programs and residential options. In selecting tenants, priority is given"... to younger physically handicapped who have the potential for basic residential self-management and staff coordination." (1981 Annual Report)

b) Services

Twenty-four hour attendant care is provided at this setting. In addition, the staff at Ten Ten assist the tenants in developing independent living skills. They also help tenants to identify alternative housing forms and support services required to meet their needs and how these forms should be modified.

c) Population

In 1982 47 physically disabled tenants resided at Ten Ten Sinclair.

d) Relative level of normalization

Ten Ten provides disabled residents with counselling and assistance in learning the personal and homemaking skills and legal responsibility necessary for tenancy and for a lifestyle which will eventually allow them real personal independence in permanent private accommodation. Thus, it is very much a preparatory form of accommodation in terms of independence. However, much of this preparation is also through actual experience in self-management of one's daily life.

Concerning integration, in a similar manner Ten Ten provides both experience with an integrated setting through its mixed disabled/ non-disabled population and preparation for future physical and social integration into the community through its programs.

2.4 Nursing/Personal care homes

a) Description

This form of accommodation is not geared specifically to the physically disabled or to any of the other disabled groupings identified above. Rather, nursing homes which have some physically (or otherwise) disabled residents are part of the general supply of such facilities, the predominant clientele for which are the elderly. The majority of physically disabled persons who are housed in these homes, then, are so placed because they are elderly and suffer from infirmities related to their age. However, in a few cases fairly young disabled persons with quite severe impairment are being housed in Manitoba's nursing homes because less institutionalized settings with high levels of care are in short supply. The only nursing home with a significant younger population is Luther Home in north Winnipeg. Nursing homes are largely funded by the provincial government, although residents do make a small per diem payment.

b) Services

These institutional settings provide long term maintenance care to their residents which includes 24 hour nursing supervision and the provision of all basic needs. Concerning services provided from the outside, the Society for Crippled Children and Adults (SCCA) through its adult program, provides some services to clients in nursing homes. These include psychological and social worker counselling, as well as vocational training for those persons with the capacity for future employment. The SCCA also encourages the use by their clients of any services available to the general community. Physically disabled persons residing in nursing homes who are also mentally retarded, receive additional services from provincial Community Services (see section 3.5 of this study).

c) Population

It appears no information is currently available concerning how many physically disabled persons are housed in nursing homes. As indicated above, however, it does seem clear that the great majority are elderly.

d) Relative level of normalization

The long-term maintenance care goals of the nursing homes and the institutional nature of their service provision do not make these settings particularly conducive to significant personal independence or to the development of the capacity for such independence.

With regard to integration, nursing homes are, by location, generally integrated into the community. However, the nature of the care provided, the institutional nature of the homes themselves and, in many cases the medical condition of the residents, would probably preclude meaningful social integration into the community for physically disabled residents. Nevertheless, some homes temper this 'isolation' somewhat by having periodic events such as teas to which the surrounding community are invited or a 'day' program for elderly persons residing in the immediate area.

2.5 Large treatment centres

a) Description

The extended care and medical and surgical wards of hospitals throughout the province and the Rehabilitation Hospital in Winnipeg are the places of residence for some physically disabled persons, predominantly the elderly, requiring extensive personal care. These persons are awaiting placement in a more appropriate setting, generally in nursing homes. Thus these centres should be viewed for the most part as short term residential forms.

b) Services

Services provided include the 24 hour nursing care and provision of all other basic needs which are characteristic of hospital care. In terms of outside services, the SCCA adult services provided to physically disabled clients in nursing homes are also available to clients in treatment centres.

c) Population

No information appears to be available on the total number of physically disabled persons who are currently housed in hospital wards in Manitoba. However, it is known that 110 physically disabled persons were residing in the Morley Avenue Municipal Hospitals in Winnipeg in 1982.

d) Relative level of normalization

For the same reasons as those cited for nursing homes, and probably to an even greater degree because of the larger scale of these institutions,

residence in hospitals largely precludes personal independence and meaningful social integration for physically disabled persons.

3.0 MENTALLY RETARDED

3.1 Self-contained residence*

a) Description

This category would include any single family dwelling, owned or rented, anywhere in the province, in which mentally retarded persons are resident. Two basic groups of mentally retarded individuals would be so housed--persons who have been prepared for and are living independently and those who are living with and have varying degrees of dependency on non-mentally retarded family members.

b) Services

The second group described above can, of course, get most of the assistance they might need in day-to-day living from co-habitating family members. This group and those mentally retarded persons

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* Mention must be made here of a new highly innovative means of providing self-contained residences to mentally retarded persons (among others), the Prairie Housing Cooperative, which got underway in Winnipeg in 1982. Despite its primary focus on the mentally retarded among the disabled, the Co-operative also attempts to provide housing to persons with other types of disabilities. Thus the PHC does not really 'fit' the grouping by grouping framework of analysis used in this paper. The Co-operative's objective is to provide its members with affordable housing on a cooperative basis and to welcome and support members (at least 25%) 'with developmental special needs'. According to the PHC brochure:

> The cooperative establishes neighboring groups of individuals or families in relatively small dispersed settings, in duplexes, townhouses, or clusters of single family dwellings. Each grouping is designed to include and support one or more handicapped members or one or two families with a child who has a handicapping condition.

Rather than being tied into particular programs for a specific disabled group (such as the provincial Mental Retardation program which is responsible for the settings discussed in this section), the PHC uses generic community services. CMHC guarantees the Co-operative's mortgages and provides subsidies to ensure the rent tenants pay is no more than 25% of their gross income.

living fully independently have access to any of the social services available to the general population.

The provincial Department of Community Services provides a wide range of services to the mentally retarded population of Manitoba through its Mental Retardation Program. These include assessment services (medical, nursing, psychological), counselling services (community service workers or specialist agencies), residential placement services, vocational services, and services oriented to child development and education. Apparently, however, the Mental Retardation Program deals with only about five percent of the mildly to moderately retarded. According to Mental Retardation Services most of the mildly retarded use the social services available to the general population.

c) Population

Approximately 27,000 Manitobans are classified as being mildly retarded, 3,700 as moderately retarded and 1,300 as severely and profoundly retarded. The great majority of mentally retarded persons living independently are probably drawn from the first and to a certain extent the second group. Those living with non-retarded family members could conceivably fall into any of the three groups, although they are probably most likely to belong to the first two groups.

Mental Retardation Services indicated that they were aware of 1,592 mentally retarded persons residing with their parents in 1982. No data are available on the number of mentally retarded who live in their own homes or apartments.

d) Relative level of normalization

Those persons in self-contained residences who are not living with non-retarded relatives clearly can experience the highest degree of personal independence in terms of lifestyle. Such a residence also ensures physical integration into the community and the greatest opportunity for social integration. For those mentally retarded persons living with non-retarded family members, the degree of personal independence and integration is probably dependent to a great extent on the particular family situation. If the family emphasizes the sheltering of the retarded person, the degree of personal independence they enjoy and their opportunity for social integration will be curtailed. However, if the family seeks a more normalized life for the individual, the self-contained residence lifestyle can be very conducive to greater personal independence and social integration for the retarded family member. The ultimate degree of normalization enjoyed will, of course, also be dependent on the degree of mental retardation of the individiual.

3.2 Supported apartment living

a) Description

This program utilizes the general supply of apartment dwellings -- retarded persons taking part are not segregated into special apartment structures. The majority of persons involved in the program are

mildly retarded. There are persons living in supported apartment settings in Winnipeg and Brandon as well as in the larger towns throughout Manitoba.

It should be noted that for the purposes of this report a person who has progressed to the point where he/she no longer needs the support program would be classified as being in the self-contained residence category discussed above. The supported apartment program should thus be viewed as a transitional 'residential state'.

b) Services

Mental Retardation Services hires a qualified person to provide training in the skills necessary to live independently and to promote such independent living. Depending on the individual's particular needs, the amount of contact with the supervisor varies from two and a half to seven hours per week. The trainer does not live with the client.

c) Population

In 1982 it was estimated that 92 mentally retarded persons in Manitoba were participating in the supported apartment program. No breakdown of this total on a regional basis was available.

d) Relative level of normalization

The private apartment style of life is highly conducive to independent living as a resident is responsible for his/her own day-to-day affairs. The individual's ability to deal successfully with the many concerns of everyday life is dependent upon the weekly training he/she receives in the supported apartment program.

In terms of integration, as noted above, the people participating in this program live in non-segregated apartments. Thus they are physically integrated into the community. This physical integration provides an excellent opportunity for meaningful social integration.

3.3 Community residences/Group homes

a) Description

It would seem that community residences and group homes are analogouss to each other, with the only major difference being that community residences are operated by community boards while group homes are privately run. Both represent a group living arrangement in which the developmental benefits of being a part of a group are emphasized. Older community residences have 10 to 12 occupants, but most now house four to eight persons. All mentally retarded persons, regardless of 'dependency' level, are eligible for community residences. The great majority so housed, however, are the moderately handicapped. Nevertheless, within each particular setting the capabilities of the residents are apparently fairly uniform.

For mentally retarded individuals with greater capability for independence, the group setting can be a transitional setting from

which they can eventually move on to a more independent living arrangement. Persons residing in a group setting are generally enrolled in outside employment training programs or are working.

b) Services

Residents of community residences are provided with 24 hour supervision and care by a live-in staff person. This individual and a trainer provided through Mental Retardation Services, also furnish training in 'lifeskills'. The level of care and supervision which is provided in the group setting, is dependent upon the general degree of disability of the group.

Mental Retardation Services provide support and direction to community groups interested in establishing community residences. As well, their Community Service Workers provide counselling to clients in residences.

c) Population

It appears that in the near future Mental Retardation Services will have accurate data on the number of mentally retarded persons in Manitoba who are housed in this manner. However, such data dealing specifically with the mentally retarded are not available at present.

d) Relative level of normalization

In-house supervision and care, an integral element of the community residence, clearly will work to limit personal independence somewhat. However, the degree of supervision and thus of independence will depend upon the degree of disability of the members of the group. A fairly high degree of personal independence within the residence is thus afforded to a group whose members have greater capabilities. A group setting with a more profoundly retarded population should also allow for a significant degree of personal control over day-to-day matters in comparison to more institutionalized settings, however. It should also be noted that preparation for enjoying greater independence is a general feature of community residences.

By their locations, group settings are physically integrated into the community. This physical integration enhances the opportunity for residents to become truly socially integrated.

3.4 Group Foster Homes

a) Description

Group foster homes in Manitoba are also known as supervised board and room settings. They have three or fewer mentally retarded residents and must be provincially approved. The foster homes provide a familial or community-type setting in which the homeowner provides friendship and

any necessary counselling and supervision to the residents. These homes are located in cities and towns throughout the province.

By far the majority of the mentally retarded who are so housed are attending training programs, although some are employed. For those who have the capacity for a fairly high degree of personal independence, this is a transitional form of housing. For a few with a more limited capacity, however, the foster home is the highest level of independence they will achieve and thus is a long-term housing form.

b) Services

The type of in-house services provided to residents apparently varies from one home to the next. Only some foster homes would provide training oriented to independent living. The division of household labour (i.e., the nature and amount of household chores for which mentally retarded residents are responsible and the household tasks which the proprietors of the home carry out) would also depend on the home. As noted above, support and direction of a familial nature is provided in all foster homes.

With respect to external services, Mental Retardation Services provide case workers who give counselling to clients in foster homes and to the proprietors of the homes. It should be noted that Mental Retardation Services also locates, screens and assesses approved foster homes and endeavours to provide support to allow them to maintain their levels of services.

c) Population

Again, although information on the number of retarded persons in Manitoba who are so housed should be available from the Mental Retardation Services shortly, no such information specifically on retarded persons in group foster homes is currently available.

d) Relative level of normalization

The presence of persons providing round-the-clock supervision in these settings represents a greater degree of dependence (and thus a lesser degree of independence) for persons housed in foster homes as compared to those residing in a supported apartment setting. Nevertheless, it would seem that the effect of this supervision can be to provide a framework within which a significant amount of latitude for independent decision-making is possible. In addition, the counselling and, in some cases, training the residents receive and the interactions and responsibilities of the foster home, provide necessary preparation for those persons who are capable of moving on to a more independent setting.

Residence in a foster home represents clear physical integration of mentally retarded persons into the greater community. This physical integration provides the opportunity for social integration beyond that which will occur through contacts with the proprietors of the homes.

3.5 Nursing homes

a) Description

As is the case for the other groupings, most of the mentally retarded persons who are housed in nursing homes are also elderly. However, apparently a small number of younger profoundly retarded persons or persons who also have other disabilities, have been placed by their families in these facilities. The goal of nursing homes can be characterized as long-term maintenance of the client.

b) Services

The in-house care is round-the-clock with an emphasis on nursing care. Services include the meal provision, housekeeping and provision of other basic needs which are characteristic of this institutional form.

Mental Retardation Services helps make referrals for persons requiring this form of housing and care and provides follow-up.

c) Population

It appears no data are available on the number of mentally retarded persons who are presently residing in nursing homes.

d) Relative level of normalization

The emphasis on long-term maintenance care in nursing homes and the breadth of this care make for a setting in which the opportunity for personal independence is greatly limited in comparison to the previously discussed housing forms.

Although the nursing homes are physically integrated into the community, the nature of the care provided and, in many cases, the medical condition of the residents, probably preclude the opportunity for much meaningful social integration in most cases. However, some nursing homes do attempt to promote a certain degree of interaction with the surrounding community through outreach programs and by holding special events such as teas.

3.6 Large residential training centres

a) Description

The Manitoba School for Retardates in Portage la Prairie and the Pelican Lake Training Centre in Ninette represent the main large institutional settings for the adult (and child) mentally retarded. However, some young adults are presently residing in the St. Amant Centre (basically a children's facility) in Winnipeg as well. Persons residing in these centres are generally profoundly retarded

and/or multi-handicapped, although the centres accommodate persons with all levels of mental capacity.

b) Services

The training centres provide a range of care and therapy programs. Particular emphasis is placed on preparing mentally retarded persons with the capabilities to live and work in the community. Services include the full range provided in institutional settings.

c) Population

In 1982 it was estimated that about 900 persons resided at the Manitoba School. Approximately seventy persons were located in the Pelican Lake Centre.

d) Relative level of normalization

The institutional setting and provision of services naturally places great limits on the scope for personal independence. Nevertheless, as noted above, emphasis is placed on preparing residents with the capability for a more independent life in the community. As well, the client and his/her needs are included in the process to come up with a plan for personal progress, and account is taken of the client's preferences in terms of training.

It would seem that the training centres' physical locations and the fact they are large institutions would preclude real integration for residents. Again, however, for those capable of life in the community, training which prepares for such integration is provided.

4.0 MENTALLY ILL

4.1 Self-contained Residence

a) Description

This category of housing would include all single family dwellings in the province, owned or rented, in which persons who are labelled 'mentally ill' are resident. Apparently the great majority of persons who have been hospitalized for psychiatric reasons return to their own home. Alternative placement thus affects only a very small percentage of the so-called mentally ill.*

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* The approximately 500 persons in Manitoba who are presently in an alternative care arrangement (i.e. in neither an institution nor their own home) are generally the chronically ill who have previously been institutionalized for a long time or have had many admissions to institutions.

b) Services

The majority of mentally ill persons living in a self-contained residence utilize the supports which are available to the general community--those provided by the family, the church, etc. An individual experiencing fairly severe problems will fall back on the help of their psychiatrist or admit themselves to hospital.

In terms of formal outside programming, Community Mental Health Services staff (Provincial Health Department) do some follow-up on previously hospitalized persons who are now at home. The hospitals provide some out-patient services and day-care programs to persons who require aid and are living at home.

c) Population

No data are available on the number of mentally ill persons presently living in a self-contained residence. As noted above, however, the indication is that the great majority of these persons are housed in this manner. With regard to the province's total mentally ill population, apparently the sensitive nature of this disability has precluded the documentation of how many Manitobans suffer from mental illness.

d) Relative level of normalization

The self-contained residence clearly provides the greatest opportunity for personal independence and, depending on individual circumstances, thus demands the most responsibility in terms of personal decision-making. Some of the circumstances which could affect one's level of independence are whether one is living with other family members and whether the family is 'sheltering' the individual from some normal decision-making responsibilities. Self-contained residences, unless in isolated locations, are of course physically integrated into the community. By this proximity they therefore provide an excellent opportunity for the mentally ill to integrate socially into the community. The degree to which these persons become socially integrated is again probably somewhat dependent upon whether they live with family and what the attitudes of the family are concerning integration.

4.2 Supervised Apartment

a) Description

Programs of this nature operate in Winnipeg and Brandon. Their goal is preparation for fully independent life in the community. Individuals taking part usually live by themselves in one-bedroom apartments, although they may share a two-bedroom suite with another person in the program. Apparently most Winnipeg participants have 'graduated' from a less normalized IGLP setting (see 4.3 below). Brandon participants, on the other hand, are referrals from a range of community sources and from the Brandon Mental Health Centre (BMHC). The apartments in which individuals

in this program reside are not segregated but are found in the general stock available to the rest of the community.

b) Services

The staff of the Selkirk Mental Health Centre (SMHC) and Mental Health Services provide the supervision of the persons in the Winnipeg program. This would appear to entail regular but infrequent monitoring of the individual's personal situation, as well as of their development in terms of capacity for complete independence and any aid which might be needed in furthering this goal. The workers also encourage the persons in this program to utilize the services and programs which are available to the general community. The Brandon program appears to be similar to that provided in Winnipeg. However, one notable difference is that the Brandon program has primarily a summer focus in which summer students as well as BMHC staff are used to administer the program and provide services ('life-skills' training, community adjustment). Following the summer, BMHC staff maintains the program on a more limited basis. The Brandon program may also place more emphasis on creating a social network among all the persons involved in the supervised apartment program than does its Winnipeg counterpart.

c) Population

Approximately 10 to 16 persons were residing in supervised apartments in Winnipeg in 1982. Ten persons were housed in this manner in Brandon.

d) Relative level of normalization

The supervised apartments provide a setting which represents a very high level of personal independence and programming which supports the furtherance of this independence. The programs also provide physical integration into the community and thus the opportunity for meaningful social integration.

4.3 Group Living

a) Description

Such settings are provided through the Independent Group Living Program (IGLP). This living arrangement is modelled on the family unit. The settings are not homogeneous in nature, having differing levels of supervision. Apparently there is also a mixing within a particular group in terms of individual levels of dependence. The majority of these group living situations include about four persons. Mental Health Services rents houses for the groups.

b) Services

There is no live-in staff in these group homes. Depending on the location, SMHC, BMHC or Mental Health Services provide programming. This involves facilitating the group process and individual development

in terms of personal independence through life skills/social skills training, and providing recreational programs. The degree of supervision/programming is dependent on the perceived needs of the client(s). In a group home where the residents have a higher level of dependency (eg. the one located in Selkirk) the supervision can be very intense, involving regular visits by care staff up to three times a day to ensure the daily routine of cooking, taking medication, etc. is followed.

c) Population

In 1982 about 60-70 persons were involved in this program in the Winnipeg and Selkirk area. About 12 persons were housed in this manner in Brandon.

d) Relative level of normalization

Concerning the independence dimension of normalization, obviously the degree of personal independence enjoyed is dependent upon the home in which one resides to a great extent. However, whatever the level of supervision, no live-in staff is involved and thus, in comparison to more institutional settings, personal and group independence must be viewed as significant. In addition, preparation for greater independence is stressed in these settings.

In terms of location, the group homes are physically integrated within the community. By their community location the homes provide greater opportunity for increased social integration. In addition, the programs provided to residents prepare them for such integration.

4.4 Supervised Group Living

a) Description

The Sara Riel Residence in St. Boniface, operated by the Grey Nuns, can best be characterized in this manner. It is geared to young adults with mental health problems. Round-the-clock care and supervision is provided at the Residence, a feature which separates it from the group settings described above. Sara Riel also differs from the independent group homes in its relatively large number of residents (capacity for 16 full-time residents). The Residence is similar to the other group settings in its transitional nature, however. In fact a termination plan with resident input is developed during a resident's stay, which is usually about six months. The general goals of Sara Riel Residence are to give dwellers a home-like experience and, through the Residence's programs, to obtain or improve certain skills necessary for independent living in the community.

b) Services

As noted above, 24 hour care is provided at the residence. The staff attempts to furnish the individual with the life and job skills necessary to allow them to move on to a more independent setting and life.

Other services provided include some supervision relating to personal care (medication, hygiene, etc.), assistance in matters such as laundry, cooking and cleaning and a semi-structured or special support system.

c) Population

Although not up to full capacity in the fall of 1982, it was anticipated that all 16 full-time places would soon be filled at the Sara Riel Residence. The Residence is designed to accommodate 15 to 20 adults on a full or day basis. In addition, the Grey Nuns apparently also provide smaller independent group homes and apartments for former residents who no longer require the level of care provided at Sara Riel. These homes and apartments would be analogous to options 4.2 and 4.3 described above.

d) Relative level of normalization

The 24 hour nature of the supervision at Sara Riel obviously provides less scope for personal independence than group settings with part-time supervision. However, as noted above, it is an integral goal of the Residence to bring about the development of the skills which are necessary to a resident's eventual independence. Part of this learning process entails a certain degree of responsibility for personal affairs.

The residence is physically integrated within the community. Thus the opportunity is enhanced for social integration of the residents. However, this opportunity may be impaired somewhat by the relatively large number of residents of Sara Riel. Such a large grouping in the midst of more normal, family-sized groupings may have the effect of 'distancing' the residents from their immediate neighbours.

4.5 Residential Care Settings

a) Description

Homes of this type are privately operated. These settings provide long-term maintenance care to their residents. The operators of such homes must agree to follow guidelines set down by the Provincial Office of Residential Care before persons are placed in the settings. Residential Care Homes vary widely in number of residents served--from as few as one to over 40. Most, however, accommodate 20 to 30 persons.

b) Services

The extent of care provided in the residential care homes also varies greatly--from what can be characterized as a boarding home with supervision to intensive in-house programming. Apparently most homes now provide a 'mid-range' level of care which encompasses room, board, help with medication and encouragement of the resident in terms of development. In all cases someone ensures that meals are on time, medication is taken and matters of personal hygiene are addressed.

Mental Health Services will provide program consultation, a treatment and/or care plan and follow-up support to persons in these settings.

c) Population

Approximately 700 persons were so housed in Manitoba in 1982, about 400 of whom were located in the Winnipeg/Selkirk area.

d) Relative level of normalization

Clearly, there is more input into and supervision of the individual's life (and thus less personal independence) in the residential care setting than in IGLP (i.e. in IGLP there is the expectation for self-care, although some household chores are allotted to residents in some care homes). As well, for most homes the emphasis is weighted more towards maintenance than on development towards greater independence.

Physical integration into the community is provided to residents in these settings. However, the degree of supervision/treatment provided in most will probably reduce the opportunity for social integration with proximate neighbours. The large number of residents in many of these settings can also work against meaningful interaction between residents and neighbours.

4.6 Transitonal Settings

a) Description

The only settings of this nature in the province, those which utilize short-term group settings to provide a transition from a large institution to greater personal independence, are Parkland Villa I and II on the grounds of BMHC. The program is administered by BMHC staff.

b) Services

The emphasis in this program is on the teaching of life skills and social skills to the residents and their preparation for 'community adjustment'. In Parkland Villa I the focus is on assessment and initial training of the participants. In Villa II the focus is more on personal development and supervision is less stringent. Both stages of the program provide 24 hour supervision, although again in Villa II it is of a less constant nature.

c) Population

In 1982, 12 persons were located in the Parkland Villa settings.

d) Relative level of normalization n

Although undoubtedly providing for more personal independence than would be available in the institutional setting of the BMHC proper, the emphasis is clearly more on preparation for independent living.

The location of Parkland Villa on the BMHC grounds clearly does not represent physical integration into the community and undoubtedly largely precludes social integration. However, preparation for such integration is provided.

4.7 Nursing Homes

a) Description

Placement of mentally ill persons in nursing homes is almost always a reflection of the fact that these persons are also elderly. These homes are geared to the long-term physical care of the elderly and their psychiatric disability represents one aspect of their needs. Thus, the nursing homes used for mentally ill elderly are the same as those available to the general elderly population and are located throughout the province. The Continuing Care Office makes the assessment on placement of mentally ill persons in nursing homes.

b) Services

In-house services are of a 24 hour nature and encompass the provision of all basic needs in the manner characteristic with institutional settings. As well some homes may hire psychiatric nurses or provide training to staff to help them better care for mentally ill residents. In terms of outside services, a person in a nursing home who meets the requirements of the Mental Health Program is assigned a Mental Health Services case worker. In addition, a psychiatrist who arranges the admittance of a client to a nursing home generally continues to maintain contact with this person.

c) Population

Approximately 350 mentally ill persons were so housed in Manitoba in 1982, 285 of whom were located in Winnipeg.

d) Relative level of normalization

The goals and mandate of a nursing home setting do not make it very conducive to personal independence or the development of such independence.

In terms of integration, although physically integrated into the community, the nature of the care provided, in many cases the medical condition of the residents, and the institutional nature of the home itself, would probably preclude the opportunity for much social interaction with persons in the community for mentally ill residents. As noted in earlier discussions however, some nursing homes do have outreach programs or events.

4.8 Large Treatment Centres

a) Description

In Manitoba these institutions include the two very large mental health centres in Selkirk and Brandon and a smaller facility in Winkler,

as well as the psychiatric wards of the province's general hospitals. The goals of these centres are to provide necessary psychiatric treatment and support, as well as preparation for re-entering the community, to the seriously mentally disabled.

b) Services

The focus of the mental health centres is acute psychiatric treatment and long term care. The duration of care would generally be shorter in the hospital wards. The mental health centres are also responsible for placing patients in alternative accommodations and for developing and maintaining alternative housing options which promote independent living. The majority of persons in psychiatric wards of hospitals apparently return home when discharged.

c) Population

In 1982 1100-1200 persons were residing in the province's large treatment centres--368 at the Selkirk centre, 554 at Brandon, 38 at the Eden facility in Winkler and about 200 persons in the province's general hospitals.

d) Relative level of normalization

The large institution setting and the acute treatment would seem to provide very limited opportunity for personal independence. However, training to prepare the individual for greater independence is provided.

The size of these settings and the nature of treatment they provide separates the centres from the community and precludes much social integration. However, again programming in these centres does provide preparation for re-integration into the community for many residents. It also provides for some outings into the community.

5.0 VISUALLY IMPAIRED

This grouping includes persons who are blind or who are "partially or intermittently deprived of sight to a serious extent" (Canadian National Institute for the Blind, Charter and By-laws, 1974).

5.1 Self-contained Residence

a) Description

This category would include any self-contained, single family residences in any part of the province, in which a visually impaired person resides. Apparently physical modifications to these homes are largely non-existent or very minor. Such modifications usually are not necessary because the great majority of the visually impaired are able to adapt to a home environment through familiarity.

b) Services

The aged visually impaired and those with temporary medical problems

are eligible for the same type of provincial support services (Home Care) as other Manitobans residing at home who have problems of a medical nature or stemming from age. Such care, which is not related to their blindness, allows these persons to remain in their homes. The majority of the visually impaired, however, are apparently largely self-sufficient and simply adjust to their environment through familiarity. The norm for most visually impaired persons living in a single family residence is to get any sighted help they may require (e.g. reading mail, help with laundry, paying bills) from family, friends or neighbours. If a person is living alone, needs such aid and cannot arrange it for themselves, the Canadian National Institute for the Blind (CNIB) will arrange for volunteers to provide necessary sighted help.

c) Population

In Manitoba 1844 persons were registered with the CNIB as blind in 1981. The CNIB concedes that not all blind persons register with them and that not all visually impaired are legally blind. Thus the total scope of the population of visually impaired in Manitoba is not known. Nevertheless, there is clear indication that the great majority of visually impaired persons, including the registered blind, reside in some form of single family dwelling.

d) Degree of normalization

Once familiar with their surroundings, most visually impaired persons in self-contained residences are apparently able to enjoy a level of independence in the home comparable to that of the non-disabled population. Co-habitation with non-impaired relatives and their attitudes on independence could again have an impact, however.

Housing of this type in most cases ensures physical integration and an excellent opportunity for social integration, the extent of which is probably largely dependent upon personal circumstances.

5.2 Room and Board

a) Description

Some visually impaired persons choose to live in room and board situations in private residences. These rooms are available to anybody, they are not geared specifically to the visually impaired. The visually impaired persons selecting this form of accommodation may do so for financial reasons (e.g. students), they may not have developed sufficient independent skills to manage their own home (e.g. cooking and cleaning skills), or they may simply prefer the contact with other people that a room and board situation provides.

b) Services

The proprietor of the house apparently provides the basic housekeeping and meal requirements of the tenants. The same type of volunteer aid arranged through CNIB which is available to visually impaired persons living in their own homes is also available to persons who are rooming.

c) Population

No exact figures are available on the number of visually impaired persons so housed, but it appears that this is a very small group. The CNIB in fact believes that more visually impaired persons would benefit from a room and board arrangement (i.e. many of the elderly visually impaired currently living in nursing homes), but that too few rooms are presently available.

d) Relative level of normalization

A high degree of personal independence would be experienced by visually impaired persons residing in a boarding house. Tenants of a boarding house are, of course, not responsible for many of their cooking and housekeeping needs. However, these are services for which they contract with the proprietor in their rental arrangement as do the other non-disabled tenants.

The boarding house situation ensures the physical integration into the community of visually impaired tenants. It would also seem to greatly enhance the opportunity for social integration with non-disabled persons (in fact more so even than for persons in single family dwellings) because of the greater contact with other tenants most of whom are likely not to be disabled, which takes place in boarding houses.

5.3 Transitional Settings

a) Description

In the CNIB's view such settings are not widely needed by the visually impaired because virtually any apartment or house can be accessible to a blind person once he/she is familiar with the setting. Nevertheless, the CNIB does rent an apartment in Winnipeg during the summer months which provides a transitional setting for one week to visually impaired young adults who are living with their parents but who plan to live on their own in the future. One or two persons can reside in the suite at a time depending on the preferences of the persons taking part in the program. The transitional apartment program began operation in 1981.

It should also be noted that in the past few years two visually impaired persons have lived at Ten Ten Sinclair, a transitional setting which mainly serves (and gives priority to) persons in wheelchairs. (See section 2.3 for further discussion on Ten Ten).

b) Services

The types of supports provided by CNIB staff to persons in the transitional apartments are geared to the particular needs of the individual. They include instruction in cooking, cleaning, household management or travelling skills. Staff do not live on the premises.

a) Population

In 1981, 11 persons each spent a week in the transitional apartment. In 1982, 15 visually impaired individuals took part in this program.

d) Relative level of normalization

The CNIB apartment provides a short term, concentrated dose of, and preparation for, independent living. The tenure is probably too short to promote social integration, however.

5.4 Hostels

a) Description

These residences resemble institutional settings, although a person has his own room and no nursing care is provided. They are large facilities which can house 50 or more persons. Hostels cater to the population in general, not simply the visually impaired. CNIB phased out the last 'blind only' facility of this type in 1979. Persons living in hostels are generally elderly individuals who do not yet require personal care.

b) Services

Meals in the dining room, laundry services etc. are provided by the in-house staff. In addition, the outside community generally encourages participation by the hostel residents in their various programs for the elderly.

c) Population

Eighty-five of the CNIB's clients were housed in hostels in various locations throughout Winnipeg in 1982. Visually impaired elderly were also located in hostels in the larger towns in the province and Brandon, although no data were available on the size of this group.

d) Relative level of normalization

Although a person residing in a facility of this type has his/her own room, a significant degree of personal independence is precluded by the institutional, highly supervised nature of the hostel.

By their locations, hostels are physically integrated into the community, although their size and number of residents clearly set them apart from the rest of the neighbourhood. The latter factor place limits on much meaningful social integration of the residents into the surrounding community. However, as was noted above, the communities in which the hostels are located apparently often attempt to promote greater contact for hostel residents by encouraging their participation in neighbourhood programs for the elderly.

5.5 Nursing Homes

a) Description

Institutional facilities of this type are located throughout the province and serve the general elderly population. Thus the visually impaired are so placed because of medical and support needs stemming from age rather than from needs stemming from their visual impairment.

b) Services

Services provided by the in-house staff are of the all-encompassing, long-term maintenance care type which is typical of institutions of this nature. (See previous discussions on this type of setting.)

c) Population

In 1982 about 232 of CNIB's clients were in personal care homes in Winnipeg. There were also, of course, an unknown number of visually impaired persons in Winnipeg nursing homes who had not registered with the CNIB. No data were available on the number of visually impaired elderly located in such homes outside of Winnipeg.

d) Relative level of normalization

The nature of services and care in this institutional type of setting would seem to preclude significant personal independence.

As is the case with hostels, it is the size of the facility (60-70 residents) rather than a remote location (these homes are located in the community), and nature and extent of services, which isolate nursing homes from the rest of the community and thus may make meaningful social integration very difficult. However, as noted previously, some homes have implemented community outreach programs to alleviate this problem.

5.6 Large Treatment Centres

a) Description

The visually impaired residing in settings of this nature for the most part encompass two groups--the elderly who may be placed in the acute care wards of hospitals while awaiting a place in a nursing home, and visually impaired persons who are also mentally retarded and are placed in the Manitoba School for Retardates. In both cases it is a factor other than their visual impairment (i.e. age or retardation) which brings about their placement in these settings. These settings can be characterized as institutional.

b) Services

Again, the in-house services available are of the all-encompassing type which are characteristic of an institutional setting. In the case of the School for Retardates, however, it should be noted that the CNIB has provided additional training to School staff to sensitize them to the particular needs of retarded residents who are also blind.

c) Population

A About 44 of the CNIB's clients were residing in the School for Retardates in 1982. Although no exact figures are available, it appears a significant number of elderly visually impaired persons are presently residing in hospitals because of a lack of available space in nursing homes.

d) Relative level of normalization

In and of themselves these settings obviously do not provide significant opportunity for personal independence or integration for their visually impaired residents. However, emphasis is placed on preparing those Manitoba School residents with the capability, for a more independent life in the community.

6.0 HEARING IMPAIRED

This group includes persons who are deaf (i.e. have severe or profound hearing impairment) and those who are hard of hearing (i.e. are impaired to the extent that communication through 'normal' means is difficult).

6.1 Self-contained residence

a) Description

This category would include any single family dwelling anywhere in the province, in which a hearing impaired person resides. Apparently a significant proportion of the hearing impaired persons so housed have had some sort of physical adaptation made to the home relating to their disability. Predominant among these are the installation of visual alarms such as door lights, smoke detectors, telephones which give off visual signals and paging systems which alert a neighbour of the need for assistance.

b) Services

Apparently most hearing impaired persons living in single family dwellings are largely self-sufficient, particularly if they have the equipment described above. Those living with non-impaired family members can utilize the hearing capacity of these relatives if necessary. As well, many hearing impaired apparently enlist any necessary hearing assistance from neighbours on an informal basis. However, telephone devices have made such arrangements less common in recent years. In terms of outside support, SCCA's department for the deaf can provide counselling to a person residing in their own homes if they so desire.

c) Population

It is believed that close to 10% of Manitobans (90,000-100,000 persons) have some degree of hearing impairment. The profoundly deaf in the province probably number about 1,000-1,500. It would seem the great

majority of hearing impaired, regardless of degree of hearing loss, reside in some form of self-contained residence.

d) Relative level of normalization

Clearly, the opportunity for the greatest degree of personal independence or responsibility for one's own affairs is provided in housing of this type.

In terms of integration, physical integration is ensured by such h housing, while the opportunity for social integration is enhanced immensely.

6.2 Independent Apartment Living

a) Description

The Kiwanis Centre of the Dead provides rental suites for hearing impaired persons (mostly those who are profoundly impaired) who desire and are capable of full independence. (It also has suites for the semi-independent and a personal care section-- see 6.3 below). The independent suites have all the features of single family dwellings including kitchen facilities, as well as the specialized devices for the hearing impaired cited in 6.1 above.

It should be noted that the Centre is not geared exclusively to the deaf. A significant minority (about 35%) are not hearing impaired. Most of these persons are elderly and have other impairments. Among the non-deaf population are also some blind and some mentally retarded individuals.

b) Services

Persons residing in the independent suites are self-sufficient and do not require the support services provided to other Kiwanis Centre residents. However, it should be noted that these tenants may, if they choose, partake in the on-going cultural, social, recreational and spiritual programs of the Centre. This group may also utilize the services available to the general community.

c) Population

The Kiwanis Centre has 141 independent suites which were all occupied in 1982.

d) Relative level of normalization

An aim of the Centre is to provide opportunity for independent living to those hearing impaired persons desirous and capable of such living, a goal which they clearly fulfil for the persons in the independent suites.

The Kiwanis Centre, although an imposing structure, is physically integrated into a south Winnipeg residential area (Ft. Rouge). In terms of social integration, the Centre's location enhances the opportunity for interaction with others in the community. As well, the Kiwanis Centre promotes such integration on its premises through its commitment to provide accommodation to persons with "...no particular impairment but who have expressed a desire to live with hearing impaired people for a mutual sharing and learning experience." (Kiwanis Centre of the Deaf, Administrative Manual, 1977). It also makes available its resources to Winnipeg's wider deaf community, thereby providing another means for residents to have contact with persons enjoying a different style of living.

6.3 Community Residence

a) Description

The Kiwanis Centre of the Deaf also functions as a community residence "... for those deaf and hard-of-hearing persons who are in need of limited or continual assistance and supervision in their daily living." These persons reside in the personal care and the semi-independent suites.

It should also be noted that some elderly hearing impaired, unable to live totally independently, move into senior citizens apartments.

b) Services

Persons housed in the semi-independent apartments at the Centre do not have their own kitchen facilities. They receive their meals in the Centre's cafeteria. These persons may also receive housekeeping service or V.O.N. nursing aid. Residents of the personal care suites generally receive medical/nursing care, basic housekeeping services and personal care services from various agencies. The Centre staff also attempts to foster individual self-development among this group and those in semi-independent suites. This is augmented for some residents by contact with social workers from the SCCA and provincial Community Services. As noted in section 6.2, the Centre also provides cultural, social, recreational and spiritual resources for interested residents.

c) Population

There are 31 semi-independent rooms at the Kiwanis Centre and 22 personal care beds. There is no clear indication of how many elderly hearing impaired persons are presently residing in senior citizens apartments.

d) Relative level of normalization

By their very designation it is obvious the Kiwanis Centre's 'semi-independent' suites allow for less personal independence than the 'independent' apartments discussed in section 6.2. Nevertheless, they and senior citizens apartments probably allow residents significantly more independence than the personal care section of the Centre. Those housed in

the latter form of accommodation, however, can receive programming which emphasizes preparation for greater independence.

As noted previously, the Centre is physically integrated within a residential area. Concerning social integration, within the Centre there is a clear opportunity for extensive contact with persons with lesser or extremely limited dependency. As well, the fact that Centre resources are open to the wider deaf community, a point noted in section 6.2 above, would seem to ensure the more dependent residents of some meaningful contacts beyond the Centre. Although segregated with other elderly persons, hearing impaired individuals in senior citizens apartments are physically integrated into the community and probably have much the same opportunity for social integration as other apartment dwellers.

6.4 Nursing Homes

a) Description

It is apparently quite common for elderly hearing impaired persons to reside in the many nursing homes located in Manitoba. The homes are of course not geared to the hearing impaired specifically but to the elderly population in general requiring a fairly high degree of care.

b) Services

Care in institutions of this type is characterized by maintenance of the resident and treatment of a medical nature. In the case of the hearing disabled residents specifically, the League for the Hard of Hearing send literature to nursing homes to make them more aware of the needs of residents who are hearing impaired and on request by a home, will make special presentations to the staff. The Kiwanis Centre staff will also make such presentations.

c) Population

No firm information is available on the size of the elderly hearing impaired population which is housed in nursing homes. An educated guess of one 'expert' is that about 10% of the elderly hearing impaired are housed in this manner. (This individual also estimates that about half of the hearing impaired are elderly.)

d) Relative level of normalization

As has been noted in previous discussions, these institutional settings can greatly limit an individual's opportunity for independence and meaningful integration into the community.

6.5 Large Treatment Centres

a) Description

Some hearing impaired persons who are also retarded (or who, because of their deafness, may appear to be so) are housed at the Manitoba

School for Retardates or at the Selkirk Mental Health Centre. These settings may clearly be identified as institutional in nature.

b) Services

In-house services are of a long-term maintenance type with an emphasis on medical treatment or training.

c) Population

It was estimated that no more than 25-35 hearing impaired persons were located in these two facilities in 1982.

d) Relative level of normalization

Institutional settings such as these clearly allow little opportunity for personal independence or integration. However, as pointed out in previous discussions concerning the Manitoba School and the Selkirk Centre, programming which prepares residents for greater independence and integration is provided in the two facilities.

7.0 CONCLUSIONS

Some general conclusions emerge from the above discussion.* The first is that a continuum of normalization does clearly appear to be a logical (and practical) way to organize existing provision of housing alternatives for the disabled and to provide a means for comparison of forms available to individual disabled groupings as well as across groupings. A second and related point is that, for each grouping, different housing forms provide distinctly different levels of normalization to their inhabitants. A third general conclusion is that many of the housing alternatives (and their supporting services) available to each of the five groupings of disabled are identical or very similar in nature across groupings. The final general point emerging from the profiles discussion is that some groupings of disabled (i.e. the mentally ill and the mentally retarded) have a greater range of housing alternatives available to them, particularly of the mid-range, community types, than others. Report #1 of this series addresses whether this last finding reflects a gap in provision for some groupings or a smaller range of housing needs.

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* For more specific, detailed conclusions stemming from the development of these profiles the reader should consult the first report of this series (Part 5).