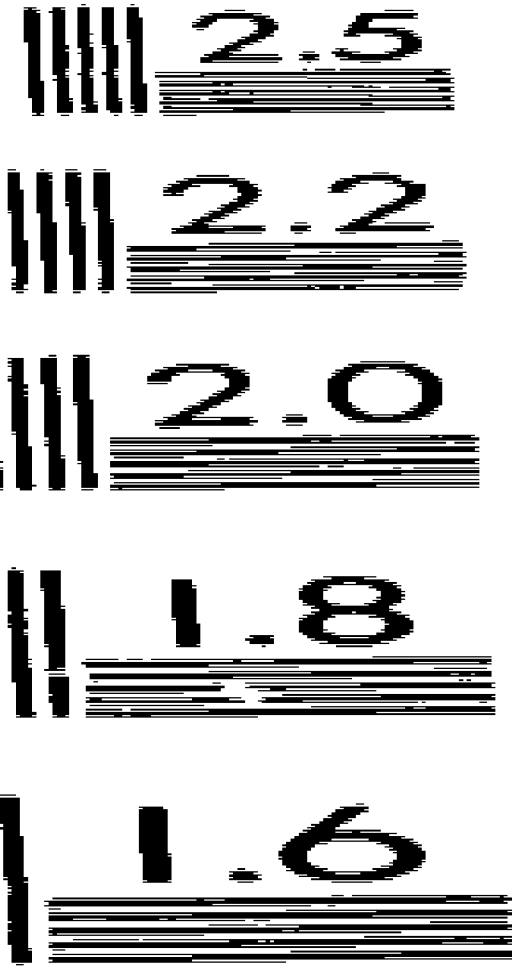

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ABSTRACT

A study was conducted for the Michigan State Housing Development Authority to gather background data necessary to initiate prototype community housing for mentally and physically handicapped independent adults. In an extensive survey and analysis of the literature and existing facilities, the problem of mental retardation, including legislation supporting construction of residences for the retarded, attitudes toward residential care, and types of residential facilities, was covered first. Second, the problem of the physically handicapped was reviewed, including architectural and transportation barriers, residential and supporting service needs, and a brief description of some housing programs. Status of residential programs for the mentally ill was also studied. Need for community housing was defined and documented, criteria describing the target population identified, pertinent socio-economic and geographic factors analyzed, similar programs and facilities identified and evaluated, and fundamentals involved in designing a housing project and services described. It was concluded that support for such programs exists among parents, the handicapped, and citizens, but that existing programs are often isolated and inadequate. Twenty-four recommendations concerning public housing for the adult handicapped are made. (KW)

WAYNE STATE UNIVERSITY
COLLEGE OF EDUCATION
DETROIT, MICHIGAN 48202

DEPARTMENT OF
SPECIAL EDUCATION
AND VOCATIONAL REHABILITATION

March 2, 1971

Mr. William G. Rosenberg
Executive Director
Michigan State Housing Development Authority
Lansing, Michigan 48913

Dear Bill:

I know we share the hope that the document we are submitting to you, as of this date, provides the information necessary to initiate a prototype program for community housing for "independent" mentally retarded adults in Michigan. As we have discussed together, so many times, the prototype dream, hopefully, will be just that for Michigan and the rest of the country for this large neglected population of the handicapped community.

We both know that many mentally retarded are initiately improperly placed in institutions and remain there because there is no other place for them to go. The dehumanization dimension of such alternatives has been distasteful to many of us for too many years. The provocative possibilities you proposed to me last Spring, in our conversation and later in your formal "outline of information," stimulated us to complete the study which accompanies this letter.

May I repeat from my "recommendations," in keeping with the feeling of professionals working with the "handicapped," and "parents," ... it seems that Michigan has an opportunity to innovatively pioneer one possible solution in the area of public housing that could provide a pattern and a direction for the entire country.

Thank you for letting us be a part of this and we look forward to continuing to work with you until the first "pilot" is a reality.

Sincerely,

Thomas W. Coleman, Jr., Ph.D.
Professor and Chairman
Department of Special Education
and Vocational Rehabilitation

TWC:fir
Encl. Michigan State Housing Development
Authority Memorandum dated July 15, 1970

DEPARTMENT OF SOCIAL SERVICES

MEMORANDUM

To: Dr. Thomas Coleman

Date July 15, 1970

From: James A. Roberts

Re: Housing for the Handicapped

Following is an outline of information which should be included in the report submitted to the Authority on activities under sections 1-A and 1-B of the Contractual Agreement between the Authority and the College of Education, Wayne State University, dated June 23, 1970:

1-A. "Define and document the need for housing for the handicapped."

(1) Identify the class of persons for which housing is to be provided, including:

(a) Age
(b) Marital status
(c) Nature of the handicap (particularly as this bears on the nature of supporting services required)
(d) Income levels (with an indication of sources of the income)
(e) Geographic concentration
(f) Employment status

(2) Identify existing arrangements for housing the class of persons described.

(3) Define the type of housing needed, including:

(a) Number of units
(b) Type of units (e.g., efficiency or 1-bedroom; single or multiple occupancy; kitchen facilities, etc.)
(c) Projected size and make-up of the initial development
(d) Supporting services required

1-B. "Compile and evaluate current literature, identify existing programs (including program sponsors and architects specializing in the field), examine existing housing developments for the handicapped around the United States, and identify private and governmental agencies operating in the field."

(1) Prepare a bibliography of existing literature and sources of data, including "technical" literature (e.g., data on special architectural requirements).

(2) Identify and provide basic information on current programs in the area of housing for the handicapped, including:

   (a) Designation of agencies administering programs, showing address, contact person and telephone.
   (b) Description of the nature and purpose of the program, including identification of all participating public and private agencies and the source of financing for the program.

(3) Identify and provide basic information on existing housing developments for the handicapped, including:

   (a) Identification of the administering agency, showing address, contact person and telephone.
   (b) Identification of all participating governmental and private agencies.
   (c) Source of financing for the construction of the development.
   (d) Source of funding for supporting services.
   (e) Information on the number and type of units, occupants, and supporting facilities.

(4) Identify any additional private and government agencies now working, or having a potential input, in the area of housing for the handicapped.

(5) Indicate which of the agencies identified in 2, 3 and 4 above are potential sponsors of a housing development for the handicapped in Michigan.

JAR:ka

A PRELIMINARY STUDY/SURVEY FOR DEMONSTRATION COMMUNITY HOUSING PROGRAMS FOR THE ADULT MENTALLY RETARDED, PHYSICALLY HANDICAPPED AND MENTALLY ILL

Project Director
Thomas W. Coleman Jr. Ph.D., Professor
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Vocational Rehabilitation, Wayne State University
Assistant Project Director
Milton Hyman, M.A., Doctoral
Fellow, Department of Special Education and
Vocational Rehabilitation, Wayne State University

This study was supported by a contract from the Michigan State Housing Development Authority of the Department of Social Services.

Department of Social Services, State of Michigan: R. Bernard Houston, Director
Michigan State Housing Development Authority, Department of Social Services, State of Michigan
William G. Rosenberg, Executive Director

ACKNOWLEDGMENTS

The writers wish to extend their appreciation to the many members of the team for the important parts they played, individually, in assisting in the study. Special acknowledgment should go to Mr. William G. Rosenberg, Executive Director, Michigan State Housing Development Authority and Mr. James Roberts, Breakthrough Director of the Authority.

We wish to express our gratitude individually to Mrs. Phyllis Kaplan Bradfield for her field work in New York and California, Dr. Richard Parres for his site evaluation, and Mr. Norman H. Hermstad for his extensive survey of west coast programs. We are indebted to Miss Sandy Schwartz for her excellent library research and Miss Toni Fontes, teacher of the deaf, for her technical work on the manuscript. Appreciation is extended to Mr. David Sokoloff AIA President of the California Association for Retarded Children and his colleague Mr. Arthur Bolton, AIA, for their fine assistance. The advice and help of Dr. William Sosnowsky is also much appreciated.

The writers are indebted to many more people too numerous to mention. However, we extend a special commendation to the many people who were interviewed and gave unselfishly of their time.

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INTRODUCTION

"The manner in which our nation cares for its citizens and conserved its manpower resources is more than an index to its concern for the less fortunate. It is a key to its future. Both wisdom and humanity dictate a deep interest in the physically handicapped, the mentally ill, and the mentally retarded. Yet, although we have made considerable progress in the treatment of physical handicaps, although we have attacked on a broad front the problems of mental illness, although we have made great strides in the battle against disease, we as a nation have for too long postponed an intensive search for solutions to the problems of the mentally retarded. That failure should be corrected." (From a statement by the late President John F. Kennedy regarding the need for a national plan in mental retardation, October 11, 1961.)

Although the above statement, by President Kennedy, was made in 1961 and reflects the then existing paucity of commitment, philosophically and materially, to the mentally retarded of our nation the sorry truth is that we have not provided significantly increased resources in the period that has ensued. It seems accurate to say that the above statement reflects the general spiritual feeling of most Americans today toward the retarded and the following quotation (A Statement of Basic Philosophy Regarding Public Education in Michigan, Bulletin No. 364, the Department of Public Instruction, Lansing Michigan, 1960.) expresses the legal obligation of the State

of Michigan to its children and youth. "Our society is concerned with the dignity of the individual and is committed to making available opportunities which will permit each person to realize his fullest potential.---.

We have come to believe that the ultimate point of reference of free men is the dignity of fulfillment of the individual. We further believe that every youngster should have the opportunity to fulfill his potentialities. Such beliefs as these can exist only in a society which is designed to respect and honor the individual, which has the strength to protect the individual, the richness and diversity to stimulate and develop the individual, and the framework of strong basic moral values within which the individual can find himself as a person."

Even more specifically our state obligates itself to its handicapped citizens in Section 8 of the Constitution of the State of Michigan which states, "Institutions, programs, and services for the physically, mentally or otherwise seriously handicapped shall always be fostered and supported." With the specificity of intent expressed in the quotations of our state it requires no additional interpretation to invoke the obligation of the state to make available adequate housing in the normal community for its handicapped citizen capable of "competitive" citizenship along with appropriate minimal supporting services. It does not require elaborate documentation to establish the formal commitment and obligation of the state of Michigan to begin to provide increased, extended, and improved facilities and opportunities for its handicapped population.

In direct response to this need, Mr. William G. Rosenberg, Executive Director of the Michigan State Housing Development Authority, at the direct request of the Governor's Office, contracted, in July, 1970, with the Department of Special Education and Vocational Rehabilitation of Wayne State University to conduct a study/survey that would provide a groundwork of information and recommendations for a demonstration public housing project for adult mentally retarded.

The contractual design of the study/survey provided for a definition and documentation of the need, identification of criteria describing the population of individuals with which the study was concerned, analyze pertinent socio-economic and geographic factors, identify and evaluate similar programs and facilities where they existed, and finally attempt to describe fundamentals involved in designing a housing "project" and services.

Many societal needs for mentally handicapped individuals are necessarily different than the public provisions made for the "normal" population. However, often the assumptions and adaptations tendered the retarded by their normal contemporaries are inappropriate, unjustified, undesired and undeserved. Yet in the few areas of deficit where accurate compensatory consideration would usually make the difference between non-competitive and competitive citizenry we usually fail to make the necessary adaptive adjustment and exceptions. The needs to which this study addresses itself are those for appropriate community housing for the "independent" adult mentally retarded.

The prevailing definition, upon which most legislation and educational rules and regulations for the mentally retarded are based, evolves from A. F. Tredgold's (1937) concept of social/biological criteria for determining mental retardation in an individual. According to this concept (Tredgold, 1937) he proposed that mental retardation is "--a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independently of supervision, control or external support." What little change in social attitude toward and "liberation" of the mentally retarded we have observed can I believe, be attributed to this more meaningful definition based on social adequacy. The ability or inability to adapt to the expectation and requirements inherent in a particular surrounding should be the only yardstick we impose on our retarded fellow human beings Because the demands and differences are so pronounced between regions and even between metropolitan and rural areas in a very narrow region this coupled with the individual's experiential capacity for adaptation will determine whether he fails or succeeds as a "competitive" citizen. When we further consider the dramatic variation of social risk within a given metropolitan area coupled with his adaptive capacity we see the unreliability of I.Q. as a criterion of social performance.

At a later date E. A. Doll (1941) in his classic article, The Essentials of an Inclusive Concept of Mental Deficiency, said, "---We observe that six criteria by statement or implication have been

generally considered essential to an adequate definition and concept. These are (1) social incompetence, (2) due to mental subnormality, (3) which has been developmentally arrested, (4) which obtains at maturity, (5) is of constitutional origin and (6) is essentially incurable."

The American Association on Mental Deficiency(1961) states that, "Mental Retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." Again, as in the preceeding two earlier definitions the key criteria is, as it should be, the capacity of an individual to adapt to his surroundings. The more recent refinements of definition and classification are primarily etiological in nature and therefore are only of academic interest for the purposes of this study.

The preceeding material on definitions conclusively illustrates the essential importance of careful assessment of the socio-economic opportunities and the cultural dangers and assets of an area in determining its appropriateness as a satisfactory housing site for the adult retarded. This inseparability, coupled with a careful assessment of the individual's social competency rather than pre-occupation with I.Q. would be vital in determining successful candidates for "independent" living.

In light of the magnitude of the problem and the numbers of retarded persons in our state it would seem unnecessary to document the problem as to incidence to justify the creation of initial demonstration facilities for the independent adult retarded. Yet,

in order to propose an initial program that hopefully would be merely the beginning of a statewide complex of housing that would eventually meet the need it is appropriate to estimate the reservoir and future resource of potential condidates for community housing.

The generally accepted estimate (President's Panel, 1962) is that 3% of the general population is mentally retarded by prevailing definition. Within this percentage there would be variations as some would be afflicted severely, most only mildly.

According to estimates based on the most recent Federal Census of 1970 the population of Michigan is 8,776,873 persons. Because of the current quality of these figures we felt there was no necessity for extrapolation in order to derive estimates based on a stable shift-in-population trend from an earlier figure.

In a recent study of the problem of retardation in Illinois (1968) their committee made some very valuable observations. Their work would seem especially pertinent to Michigan because of the similar features of the two states. A part of the Illinois study pointed out that, "One out of 30 mentally retarded persons is severely retarded and will always be in need of nursing service and care. Four out of each 30 mentally retarded are semi-dependent and may be able to remain in the community with adequate supervision and care. Twenty-five out of each 30 mentally retarded are marginally independent and will need community resources and aid to prepare them for a more independent life. The retarded can be helped. Four out of each 30 who are semi-dependent can be trained for their personal needs; Many can participate in sheltered work programs and perform simple

tasks at home. Twenty-five out of each 30 can be educated in basic reading, writing, and arithmetic and can be gainfully employed at semi-skilled jobs."

Classification by intelligence quotient from the American Association on Mental Deficiency (American Association, 1961) describes the general population of retarded persons as, "mild retardation (Educable Mentally Retarded), which includes those retardates with an I.Q. within an approximate range of 52 to 83; Moderate retardation (Trainable Mentally Retarded), which includes those retardates with an I.Q. within an approximate range of 36 to 51; Severe retardation (Severely Mentally Retarded), which includes those retardates with an I.Q. within an approximate range of 20-35; and Profound retardation (Profoundly Mentally Retarded), which includes those retardates with an I.Q. below 20." From the gamut of population described by the association any potential group for independent housing would necessarily be predominantly drawn from the EMR group.

Therefore, in our analysis of Michigan's population of the retarded emphasis is given to the EMR group who would have the higher potential for social adequacy. Applying the 3% figure for retardation in the general population to the 1970 Federal Census figures, Michigan would have statistically a population of 263,306 individuals. This is only a gross estimate based on a national estimate and has no value for program, service, and facility purposes.

If the widely accepted figures of the National Association for Retarded Children (National Association, 1954) of 25 per 1000 persons

being marginally dependent, 4 per 1000 persons being semi-dependent or trainable and 1 per 1000 persons being dependent are applied to the estimated 1970 Federal Census figure one arrives at more meaningful population figures for our purposes. Application of these estimates indicate Michigan has 219,400 marginally dependent retarded, 35,104 semi-dependent (trainable) retarded and 8,776 dependent mentally retarded. In order, however, to arrive at numbers that have meaning for the purposes of this study several approaches must be considered.

Michigan's distribution of population by chronological age is as follows.

Age	-	Percent of Population
0-5	-	9.5
6-17	-	27.8
18-44	-	34
45-64	-	20.2
65 or over	-	8.5

If we apply those categories of the distribution pertinent to a population available for housing it would chronologically, generally, cover the 18 years to 64 years range. The total percentage of population in this range is 54.2 percent. Submitting our retarded population to the above distribution we obtain the following breakdown.

Number of Retardates	Level of Retardation
219,400	marginally dependent
(118,915)	(between ages 18-64)
35,104	semi-dependent (trainable)
18,776	dependent

Before even considering the variabilities of individual adjustment and social maturity that would effect the numbers of individuals in the marginally dependent group capable of "independent" living we must

consider other phenomena that effect this estimate.

Although as we have mentioned earlier it is customary to use a figure of 3 percent of the total population or 30 individuals per 1000 of population to arrive at gross statistical estimates these methods do not provide our most reliable figures for program and facility planning. It is more meaningful to use the variable estimates developed in Illinois (Scheerenberger, 1966) in which the percentages of the population considered to be mentally retarded varies with chronological ages. Using the variable approach developed by Scheerenberger (1966) the estimate more nearly approximates 2% of the total population. Under this formula the percentage of individuals estimated to be Trainable Mental Retardates, Severely Mentally Retarded and Profoundly Mentally Retarded remain constant with chronology. According to the Illinois study (1968), "The only variance between the estimated mentally retarded population associated with the variable approach and an estimate based on a constant 3 percent is reflected in the Educable Mentally Retarded population."

If one adopts the rationale underlying the variable approach, as proposed by Scheerenberger (1968), and applies his figure of 1.6 percent of the total population to the marginally retarded group in Michigan we derive an estimate of 140,416 individuals.

For the specific purposes of this study 54.2 percent or 76,105 individuals would comprise the base target population for the type of facility/program implicit in the study. However, caution is dictated in applying even this estimate as it is difficult to fix, definitely, such influences as life expectancy and emotional, physical, and

social deprivation, etc. However, even if unlimited financial resources for facilities for the retarded became available overnight it would take many years to provide appropriate community programs for the well qualified portion of the marginally mentally retarded group.

Although there are no definitive studies of sex and incidence in mental retardation all of the information in the literature reflects that there is a larger prevalence of males as compared to females. Males seem to exceed females more in younger age groups than in older groups. The higher incidence of mental retardation among males is well supported by much general historical data even though factual studies are almost non-existent. Even if we assume a 50-50 distribution at adulthood, sex would not seem to be significant as a quantitative factor for concern in developing a successful housing program for the adult retarded in the community.

Employment as a crucial variable in its relatedness to housing for the independent mentally retarded must be considered. Although a myriad of independent and unfortunately isolated studies have been done over the years in the general areas of employment and social adequacy most seem to support the general implication of the Fernald's (1919) survey. His follow-up study of 1537 persons discharged from an institution for the feebleminded over a twenty-five year period indicates that over 51 percent of the females had remained in the community and were experiencing no difficulty. Although 42 percent of the females had histories of sexual offenses, alcoholism and theft only 4 of the group had been committed to correctional institutions.

Fernald (1919) studying his females found that the well-adjusted females had received better "acceptance." Acceptance consisted of support and friendship from friends and relatives coupled with socially acceptable outlets.

As to the males in his population, 64 percent remained in the community. He found them distributed in roles varying from living totally self-supporting and living independently to some being employed and living at home and some living at home and not working. Among the males he found community adjustment to be greater than among the females and anti-social behavior was less. These classical facts from the study indicate that in the ensuing period of over 50 years there is a large and waxing population of marginal mentally retarded, both male and female, who can operate with full independence with a minimum of supportive service. When one considers that there is a general consensus among experts in the field that "training for life within an institution may be very inappropriate training for life outside the institution," (Windle, 1962) and that Fernald's population had been institutionalized for varying periods of time there is reason to be very optimistic about the need for and success of housing for independent living for the adult mentally retarded.

II

SURVEY OF THE LITERATURE

MENTAL RETARDATION

The Problem of Mental Retardation (MR)

Mental retardation is one of our most pressing social concerns. The problem of providing appropriate educational, vocational, and residential services for the mentally retarded is increasing proportionately with a United States population which is now over 200,000,000. For example, the United States Department of Health Education and Welfare reported in 1969 that there are over six million mentally retarded individuals in the United States, or in other words about three per cent of the population has the burden of mental deficiency (U.S. Department of Health, Education and Welfare, 1968). This ratio is, also, proportional in respect to percentage of mentally retarded receiving some kind of residential care. Thus, there is one MR bed per 100 population, and the United States average is about 92 per 100,000. In 1968, admissions for the mentally retarded were 7 1/2 per 100,000 population (Interview of Sloan).

Since the degree of mental retardation varies in degree with each retarded individual, assigning a specific definition is difficult. However, the American Association of Mental Deficiency gives the following general definition:

> Mental retardation is (characterized) by the subaverage general intellectual functioning which during the development period and is associated with impairment in adaptive behavior. (Dybwad, 1964)

The degree of variation in mentally retarded persons is usually

sub-defined in the following I.Q. categories (U. S. Department of Health, Education, and Welfare, 1969):

Borderline	=	I. Q. 68-88
Mild	=	I. Q. 52-67
Moderate	=	I. Q. 36-51
Severe	=	I. Q. 20-35
Profound	=	I. Q. less than 20

The United States Department of Health, Education and Welfare has an adaptive behavior classification for the mentally retarded which gives the following prognosis (U. S. Department of Health, Education, and Welfare, 1969):

Mild

Development is slow. Children are capable of being educated (educable) within limits. Adults, with training, can work in competitive employment. They are able (with the proper supporting services) to live independent lives. (This type of individual could probably meet the requirements for the Michigan State Housing Authorities Program for Housing for the Adult Handicapped.)

Moderate

They are slow in their development, but are able to learn to care for themselves. They are capable of being trained (trainable). Adults need to live and work in a sheltered environment.

Severe

Motor development, speech, and language are retarded. They are not completely dependent but often are physically handicapped.

Profound

They need constant care or supervision for survival. They show gross impairment in sensory development. Often they are physically handicapped.

Legislation: Support for Construction of Residences for the Mentally Retarded

Federal (and state) support for categorical construction programs is a relatively new principle. Prior to 1963, no Federal legislation existed to support construction of facilities specifically designed for the mentally retarded. In the same year Congress enacted the 'Mental Retardation Facilities and Mental Health Centers Construction Act (P. L. 88-164). Since the enactment of this legislation in 1963, three different but interrelated construction programs for the retarded have been initiated: Research Centers, University-affiliated Facilities and Community Facilities. P. L. 88-164 authorized appropriation of 329 million dollars over a five year period to provide grants for construction of mental retardation facilities; grants for training professional personnel in the education of the handicapped and grants for conducting research relating to the education of the handicapped. Title I, Part C, of P. L. 88-164 has special significance for state housing authorities concerned with the construction of residential facilities for the mentally retarded (U.S. Department of Health, Education and Welfare, 1969).

This Act provides Federal grants to states to assist in the construction of specifically designed public or other nonprofit facilities for the diagnosis, education, treatment, training, or personal care for the mentally retarded. The program is administered at the state level by an officially designated state agency. Participation in the program requires the development of a state plan for the construction of community facilities for the mentally retarded based on an inventory of needed additional services and facilities. Construction projects are approved in accordance with the provisions of a state plan. As of 1968, 242 state projects had been approved for Federal assistance. The total estimated cost is approximately 143.5 million dollars and the estimated Federal share is 48.4 million dollars (U.S. Department of Health, Education and Welfare, 1969).

Most of the 50 states have enacted some legislation which deals in some way with the construction and administration of residential facilities for the mentally retarded. However, Wisconsin and Illinois appear to have two of the more comprehensive legislative programs. For example, section 48.48 of the Wisconsin Statutes implies a state responsibility for initiative in all matters relating to the interests of the mentally retarded. Section 51.22 has been interpreted by counties to imply a fixing of responsibility for services to the retarded with the state through public and private residential facilities (Wisconsin Mental Retardation Planning and Implementation Program, 1969). Sections 46.22, 48.57, and 49.51 of the Wisconsin Statutes states that every county welfare department is responsible for providing a variety of services (including residential services) to the mentally

retarded.

The 75th General Assembly of Illinois (1967) passed two bills with regard to construction of new residential facilities. House Bill 2221 provided for the construction of one new facility and allocated $8,977,500. Senate Bill 950 provided for the construction of six additional facilities in northeastern Illinois in an amount not exceeding $54,000,000. House Bill 2221 also allocated $5,250,000 for the construction of one new mental retardation research center (Sloan, 1969).

Michigan, California, New York, and Texas have also initiated ambitious legislative programs for the construction of residential facilities for the mentally retarded. Under the provisions of Public Law 88-164 (Federal), Texas is planning 43 residential programs for the mentally retarded at an estimated cost of 32.6 million dollars (Conference Report of the Architectural Institute, 1967).

Attitudes Toward Residential Care for the Mentally Retarded

Although scholars and experts in the field of mental retardation show divergent approaches concerning the area of appropriate residential facilities, there appears to be general agreement in four areas: (1) There is an urgent need to improve and increase residential facilities for the mentally retarded. (2) The adverse affect of institutionalization on a significant number of retardates. (3) Any residential facility for the mentally retarded without a comprehensive program of supporting services would be ineffective. (4) The barrier which antiquated zoning laws present to the establishment of community

residential facilities for the retarded.

The President's Committee on Mental Retardation, in its report of 1969 emphasized the poor status of residential care for the mentally retarded. Overcrowding, understaffing, and underfinancing are the major reasons for this residential dilemma. To complicate matters, the public, long accustomed to knowing little about mental retardation, often held inaccurate information, and there has developed a mystique about the retarded involving feelings of hopelessness, repulsion, and fear (President's Committee on Mental Retardation, 1969). Although there appears to be a gradual change involving a more understanding attitude toward the needs of the retarded, there is still much progress to be made.

Unrealistic zoning laws are a reflection of the public's attitude toward the mentally retarded. For example, twenty-six communities in Wayne County were contacted by staff members of the Plymouth State Hospital and Training School in order to find out if their zoning laws could accomodate multiple housing for the mentally retarded. All the communities gave negative responses. The Dearborn Association for the Retarded wanted to establish some residential units in an abandoned elementary school in Dearborn. They could not by the Dearborn Zoning Board. These zoning boards appeared to have the misconceptions about the retarded, that establishment of residences for retarded in their neighborhood would constitute a danger for their wives and children (Ebling, 1970). The barrier of zoning laws combined with the high cost of land in urban and suburban areas further increases the difficulty in establishing community based residences for the retarded.

For example, urban renewal land is selling for $175,000 an acre in Detroit (Woodward Corridor area). According to the Detroit City Planning Commission 50 x 122 foot lots near the central city are selling for about $30,000. Eight lots were priced on an average basis in some of Detroit's inner city areas and the average was $21,000 an acre (Ebling, 1970). The state of zoning in many communities is summed up by J. W. Reps in the following excerpt:

> Zoning is seriously ill and its physicians, the planners, are mainly to blame. We have unnecessarily prolonged the existence of a land use control device conceived in another era when the true and frightening complexity of urban life was barelyappreciated.... What is called for is legal euthanasia, a respectful requiem, and a search for a new legislative substitute sturdy enough to survive the modern urban world....

Although there are a considerable number of institutionalized residences in which the mentally retarded receive adequate or exemplary care, the fact remains that there are far too many borderline or mild retardates in such institutions. In a time when there is an urgent need for the construction of non-institutional residences, it is apparent that the construction of institutions is increasing. For example, institutional construction increased by 54 per cent since 1954 to a high of 154 institutions in 1966. New York State, with sixteen institutions, Michigan with ten institutions, and Pennsylvania with nine institutions lead the nation. From 1950 to 1966 resident patients in institutions in the United States increased at an annual rate of three per cent from 147,000 to 191,000 . The resident population of public institutions contains about 3.2 per cent of the estimated mentally retarded but contains about 48 per cent

of the estimated 400,000 severely mentally retarded in need of residential care. It is estimated that there are 17,000 mentally retarded in private institutions and an additional 43,000 in mental institutions. In 1965, there were over 9000 full professional personnel employed by institutions to care for the mentally retarded (Health, Education and Welfare, 1968).

Unfortunately, many mentally retarded are improperly placed in institutions. Some institutions, according to the National Association of Retarded Children, have failed to eliminate a dehumanizing environment (Bingham, 1968). They feel that a more concentrated, all encompassing approach must be developed if humane conditions for retarded persons are to become realities. This will require a systematic and on-going critical analysis of those practices, systems, and policies which contribute to this process of dehumanization which results in overdependency, lack of meaningful relationships, lack of self-esteem, cultural and sensory deprivation, and lack of individual programming (National Association for Retarded Children, 1968).

Blatt and Kaplan in Christmas in Purgatory, discuss and study five state institutions for the mentally retarded located in the Eastern states. Their findings were discouraging:

> ....These conditions are not due to evil, incompetent, or cruel people but rather to a conception of human potential and an attitude toward innovation which when applied to the mentally defective, result in a self-fulfilling prophecy. That is...if one things that defective children are almost beyond help, one acts toward them in ways which then confirms one's assumptions.

An examination of different federal and state residential

programs for the mentally retarded, and expert research in this area indicates an increasing trend in opinion that supporting services are the most crucial considerations in establishing residential programs for the retarded. This emphasis in the importance of services is pointed out in the President's Committee on Mental Retardation's definition of a residential facility for the mentally retarded:

> A residential facility for the mentally retarded is any housing facility other than the individual's natural home, which provides supervised living with appropriate services related to the individual's needs. (1970)

The President's Committee feels that residential facilities for the mentally retarded, thus, should be considered as only one component of a continuum of services. They emphasize that nothing is as convincing of the viability of a broad service system as visiting and seeing one in operation (President's Committee on Mental Retardation, 1969). According to the President's Panel on Mental Retardation (1967), programs for the retarded should be comprehensive and community centered. They should be so organized to provide a central or fixed point for guidance, assistance, protection, if and when needed. Also, there should be an assurance of a sufficient array or continuum of services to meet different types of needs. Finally, private agencies as well as public agencies at state, local and federal levels should continue to provide resources and to increase them for this worthwhile purpose (Sloan, 1969).

The above approach is consistent with the assumption that community based services are needed to replace institutions for many mentally retarded. One needs such things as regional planning, prenatal care,

early detection and recreational programs. The type of housing structure or unit must vary with the individuals' mental level, age, and physical condition. Thus, it can be advised that residential programs for the retarded in Michigan should be developed in respect to differences found in Michigan and similarities found in other states (Interview of Sloan). For example, Michigan has different residential needs than Idaho but may have some similarities with Ohio or Illinois.

However, the lack of community services and appropriate residences is indicated by the large waiting lists of mentally retarded to enter state institutions which shows that many needs of the retarded are not being met. This is pointed out in a study by the Illinois Department of Public Health which attempted to delineate the specific needs and characteristics of waiting list applicants to Illinois State schools. The sample came from 1,442 applicants waiting admission and all levels of retardation were represented. It was discovered that two out of ten applicants spent their leisure time alone and inactively. Four out of ten responsible persons felt that the applicant's care would deny other family members needed care. It was recommended by this study that services such as part-time care facilities which would provide companionship for the retarded, relieve strain of caring for the retarded, give parents more time to care for other children. These part-time facilities could be day care or temporary residential units (Illinois Department of Public Health, 1965).

There is a trend toward advocating smaller residential unit concentrations for the mentally retarded. The President's Committee on

Mental Retardation feels that the desirability of building large facilities of 1,000 or more is still controversial. Many facilities are of this size or larger, and more are being constructed. There is preliminary evidence to suggest that smaller facilities (perhaps 150 persons or less) can be constructed and operated at no more than the cost now being utilized in the larger facilities, perhaps even at less cost (President's Committee on Mental Retardation, 1969). However, the size and types of units should be based on the needs of the residents.

There is a growing belief among experts in the area of mental retardation that borderline and educable mentally retarded can live in normal type dwellings, and when they are placed in such residences, a variety of support alternatives should be tested. They believe in this rule of thumb. In housing for the mentally retarded, one should strive for normal conditions (as much as the degree of retardation indicates). The retarded should have a minimum degree of isolation and that the maximum degree of normal conditions should be tested. Certain individuals, will need more support while others will need less. These programs should be followed by careful observation. Since mentally retarded individuals show a wide range of abilities, they will need a wide and diversified range of supporting services. Initially, Housing for the Adult Handicapped Units could serve as demonstration units or models in care for the retarded (Bolton and Sokoloff, 1970). Perhaps the statement by Dr. Bengt Nirge in the President's Committee Report on Mental Retardation, is a precise explanation on the goal of normalization in housing for the retarded. Dr. Nirge states:

> Thus, as I see it, the normalization principle means making available to the mentally retarded patterns and conditions or everyday life which are as close as possible to the norma and patterns of the mainstream of society. This principle should be applied to all the retarded regardless of whether mildly or profoundly retarded, or whether living in the homes of parents or in group homes of other retarded.... An important part of the normalization principle implies that the standards of the physical facilities.e.g., hospitals, schools, group homes and hostels, boarding houses, should be the same as those regularly applied in society to the same kind of facilities for ordinary citizens. (1970)

In the following paragraphs various residential facilities, and approaches to supporting services will be briefly described. There are many types of residential facilities for the retarded but they are generally of the following types:

1. Family care programs
2. Residential care institutions
3. Halfway houses
4. Boarding homes
5. Temporary care
6. Foster homes for adults
7. Foster homes for children
8. Living independently

The Wisconsin Division of Health and the Bureau of Planning, Education and Research, Division of Mental Hygiene, defines the housing facilities mentioned above (1968-69):

Family Care Programs:

Family care is directed towards persons of all ages who have been in or are presently residing in State Colonies and Training Schools. The program, aimed primarily toward rehabilitation, provides opportunities for improved functioning of the mentally retarded person through school attendance, vocational training, employment and participation in community activities. Family care may be used either as a step toward independent living or as an indefinite placement.

Residential Care Institutions:

The residential care institution is for an individual whose mental or physical abilities indicate the need for independent living but in the framework of a well-structured program. These facilities have provisions for providing social care, social services three hours per resident per month, and activity therapy and activity services three hours per resident per month.

Halfway Houses:

A halfway house is a small group residence for adults who usually have been residents of a State institution and who have demonstrated readiness to adjust to community life in a supervised setting. Independent community living is the goal for the residents of a halfway house. Employment workshop training would be part of their community program. There may be a time limitation in the use of the halfway house.

Boarding Homes:

A boarding home is a board and room arrangement that provides an experience in social living, but is not considered to be a treatment or rehabilitative facility. Treatment services remain entirely the function and responsibility of the referral source. The retarded within this type of facility are able to take care of their own personal needs. This type of facility would serve the long-range living needs of some adult retardates. Necessary social, vocational and educational services should be offered in the community. Although this type of facility must meet physical standards of the Department of Industry, Labor and Human Relations, Industrial Safety and Buildings Division, there are no standards of operation or licensing of boarding homes.

Temporary Care:

In general, temporary care means short-term care for the retarded child or adult outside of his own home during family emergencies, vacations, or to relieve the parents from the constant pressures of caring for their child. In order to assure that a retarded person is receiving short-term care oriented to his specific needs, each type of community residential facility should set aside one or two beds specifically for temporary care purposes.

Living Independently:

The retarded adult who has shown ability to function independently in living environment such as a rooming house, apartment, or YMCA or YWCA should have direct access to a local fixed point of referral. This serivce would be helpful to assist the borderline retarded individual to make a good adjustment to the community within which he resides.

Thus, Wisconsin offers a comprehensive program of services in

regard to residential facilities for the retarded. The objectives of the Wisconsin program areto unify efforts, evaluate existing programs, narrow gaps in services, plan boldly and set new goals. Wisconsin advocates the concept of shared responsibility by all levels of government, private, voluntary agencies, and the general public(Wisconsin Mental Retardation Planning and Implementation Program, 1969). Wisconsin is heavily dependent on community based public and private programs that enable many retarded persons to remain in their own homes or other community based residential facilities. An attempt is being made toward the development of a continuum of community living experiences. This is made possible by a variety of residential alternatives (already defined on in previous paragraphs). Their goal is to develop mutual understanding within each service area as to a definition of each of these types of facilities (Wisconsin Mental Retardation Planning and Implementation Program, 1969).

An excellent example of an independent residential facility for retarded, with appropriate and comprehensive services is provided by Council House, Milwaukee, Wisconsin. This program is sponsored by the Milwaukee Council of Jewish Women, and the Milwaukee Jewish Vocational Services. They believe that there is a great need for group living for the mentally retarded in order for them to be integrated into society. Their funds are limited and they have renovated two old homes on 2003-2007 West Kilborn. The program is divided into three phases. Phase I has one house for females and one for males and is supervised 24 hours per day. The staff of the Council of Jewish Women

Services, supervises these dwellings. Phase II has a rented duplex where there is minimal supervision. There is a housemother and a housefather who come in two or three times a week as do other supporting staff. In Phase II physically handicapped are sometimes mixed with the retarded. Most of the residents in Phase II are employed in a competitive working situation (Malnekoff, 1970).

In Phase II, the clients live together and pool their financial resources. There is no supervision but there are supporting services. There are three girls in one flat and two boys in another flat. The rent is $105. per month and food runs about $18. per week. Although the Council of Jewish Women would prefer that they could service newer or more modern residences, it is their philosophy that the services for the retarded are much more important than the actual physical residence. Some of the supporting services, instruction and training of Council House residents are:

1. Laundering
2. Cooking classes
3. Banking and shopping
4. Tutoring by college and high school students
5. Vocational classes in sewing, woodworking
6. Speech therapy
7. Recreational facilities
8. Jewish Center Saturday Guidance Program
9. Monday nights is for group counseling. The residents discuss their problems. Speakers come from the police, and fire department etc. (Malnekoff, 1970)

The Illinois Department of Mental Health, Division of Mental Retardation, like Wisconsin, believes in a comprehensive program of supporting services to accompany any residential plan. In the state of Illinois the care for the mentally retarded is divided into eight zones or planning regions. It is the concept of this approach that

each geographical zone represents different needs for the retarded. An example of a zone summary is one which includes (Murphy, 1967):

1. Population
2. Number of mildly and severely retarded
3. Available residential beds
4. Specialized programs
5. Geography etc.
6. Retardates holding jobs

Thus, housing is only one facet of the services provided the retarded in Illinois. It is also the belief of the Illinois Department of Mental Health that local generic services must play an increasingly important role for the retarded if an effective continuum of care is tobe provided. A generic service is defined as (Scheerenberger, 1969):

> Any health, education, welfare, rehabilitation, or employment agency in the community which serves a broad spectrum of persons including the mentally retarded.

Although the State of Illinois believes that educable, borderline or mild retardates should be taken out of institutional dwellings, there is a trend in Illinois to build large apartment complexes or centers for the retarded. An example of this is the Elizabeth Ludeman Mental Retardation Center, Park Forest, Illinois. The sponsor is the Illinois Department of Public Health. This center is located on a sixty acre site and is designed to provide as homelike a setting as possible for 400 severely and profoundly retarded individuals. It was built at a cost of $9,000,000 (Elizabeth Ludeman Mental Retardation Center, A. Epstein & Sons).

Another example of a large non-institutional residence for the mentally retarded in Illinois is Unit-Care located in Aurora which has about 500 rooms. The Unit-Care Organization purchased the Hilton Inn

in Aurora for about $4,000,000 and are now using this structure for about 450 mild and moderately retarded adults. Aurora is about 40 miles from Chicago (Interview of Sloan).

The California approach to residential needs is similar to that advocated by Wisconsin and Illinois: that housing for the retarded is but one facet of a comprehensive continuum of services. However, California advocates the team approach in services for the retarded. It is their philosophy that through the combined effort of the individual staff members on the professional team, the expectation is that learning, and training situations can be individualized to meet the needs of each retardate. It is the belief of this approach that it is the job of special education facilities along with other generic services to prepare a retarded individual for independent residential living before and after he has reached adulthood. (California Department of Rehabilitation and Mental Hygiene)

An example of this approach is shown by a cooperative agreement between the California Department of Mental Hygiene and Department of Rehabilitation (May, 1966). This agreement created a habilitation and treatment program for approximately 500 retardates. The goals of this program are the following: to provide an independent program of services to help each resident student reach maximum development; to rehabilitate as many mentally retarded as possible so that they may become better adjusted and productive members of the community; and to include competitive employment or sheltered employment in the community (California Department of Rehabilitation and Mental Hygiene, 1970).

Both California and Colorado, as does Wisconsin, appear to favor

smaller types of residences for mentally retarded who are in need of long term care. Denver's residential program for young adult retardates is similar to the Council House program of Milwaukee. This program is supported by the Health Services Development Grant Number 83994. In this program a four apartment section of a public housing project was leased. Ten young adult retardates reside in these dwellings (ages 16-25). A house parent couple is employed to give supervision. The goal of this program is a homelike atmosphere and to guide them toward skills for more independent living than they could achieve in a typical institution (Scheer, 1970).

PHYSICALLY HANDICAPPED

The Problem of the Physically Handicapped

The most recent analysis of the extent of physical disability in the United States was made in 1968 for the Department of transportation. Using data from the National Center for Health Statistics, this analysis indicates that the following number of people have conditions which would be less handicapping if environmental barriers were eliminated (Lauder, 1969):

Chronically disabled. . . . . (including aged)	6,093,000
Disabled by:	
Injuries and diseases	4,642,000
Age (non-chronic conditions). . . .	15,281,000
Pregnancy (3 to 9 months)	2,097,000
Institutional population . . . . . (Exclusive of aged and bedridden)	1,339,500
	29,644,500

These figures coincide with the Public Health Education Survey (1963-1968)which indicates that there are probably over 30,000,000 handicapped individuals in the United States and that this number also will increase to over 40,000,000 by 1985 (The President's Committee on the Employment of the Handicapped). Also, in 1963 the United States Department of Health, Education, and Welfare estimated that between fifteen to twenty per cent of the total population is affected by architectural barriers and lack of safety features. This portion of the population was broken down into the following categories:

5 million with heart conditions
250,000 in wheelchairs
200,000 with heavy leg braces
16.5 million over 65

Between 1962 and 1969 there was an increase of 5 million in the United States with limited mobility (Chatelain, 1963). There is, also, evidence to indicate an individual's physical handicap can have a direct bearing on his employability and earning power. For example, only one per cent of employed men in the United States are severely disabled. The disabled in the labor force can be categorized in the following manner:

Disabled in labor force (working or seeking work)
19% of severely handicapped; 65% of seriously handicapped; 73% of moderately handicapped
Employed full time
20% of severely handicapped; 43% of seriously handicapped; 63% of moderately handicapped
Employed part-time
14% of severely handicapped; 16% of seriously handicapped; 6% of the moderately handicapped

The Public Health Survey of 1965 researched family incomes of the disabled. Sixteen per cent of all families had incomes of $3,000 or less; 25% had $10,000 or more. However, the low income group had four times as many disabled people (Health, Education, and Welfare, 1969).

	Number of Disabled
Under $3,000 per year	8,805,000
$3,000-$3,999 per year	2,333,000
$4,000-6,999 per year	5,202,000
$7,000-$9,999 per year	2,767,000
$10,000 and over	2,249,000

Thus, it can be seen that the proportion of the disabled in the population is growing as modern life becomes more hazardous. In 1967 there were 1,200,000 injuries due to auto accidents. There are two million children with orthopedic handicaps and there are 100,000 babies born each year with congenital impairments (Lauder, 1969).

Barriers

The fact that there are over 30 million disabled persons in the United States indicates that there will be a pressing need to provide appropriate housing and to make as many public and private dwellings barrier free. This appears to be a most difficult undertaking. The State University Construction Fund of New York State says that the physically handicapped are continuously burdened by architectural barriers. Buildings have been designed to meet the needs of the average man (State University of New York, 1967). Consideration has not been given to those individuals who are handicapped. In every community, almost all the buildings and facilities most commonly used by the public have features that bar the handicapped (Lassen, 1969). The following is a description of a handicapped individual's visit to the Federal Court House in Washington D.C. (Chatelain, 1963):

> ....it covered a whole city block.... huge entrances reached only by a great flight of steps. The vehicle (wheelchair) entrance had a dangerous incline. I negotiated a ramp, loading dock, the buildings' boiler room, and finally reached the freight elevators, which did not stop at my floor. After going down another floor, I finally reached my destination.

It is essential that the public should be made aware of this existing sensitivity gap. They should become aware of the problems which prevail for handicapped persons in regard to construction of public and private buildings (Department of Health, Education, and Welfare, 1969). The United States Department of Health, Education

and Welfare's 1967 publication Design for all Americans, claims that this sensitivity gap has been the greatest obstacle to the employment of the handicapped. This is due entirely to the failure to think of the handicapped person's needs during the design and planning stage of construction. These barriers include:

1. Steps and curbs.
2. Inaccessible elevators.
3. Steep and narrow walks; gratings in walkways.
4. Doors that are too narrow, revolve, or are hard to open.
5. Lack of parking spaces reserved for the handicapped and designed for their use.
6. Lack of accomodations for wheelchairs in theatres, stadiums, and other public gathering places.
7. Too narrow aisles in cafeterias, restaurants, libraries, and auditoriums.
8. Too small public toilet stalls, telephones, and drinking facilities.
9. Too high telephones, drinking fountains, vending machines, light switches, and fire alarms.

Not only are the physically handicapped burdened by architectural barriers in buildings but they are also hindered by travel, or transportation barriers. The Department of Transportation states that approximately 6 million physically handicapped individuals whose mobility is limited as a result of a chronic or long term medical condition. They claim that the travel barriers which presently pose the most difficulty for the physically handicapped are the dynamic, movement oriented barriers which are characteristic of our present transportation system, acceleration, crowds, time pressure, and jerking. Projection of future disability to 1985 indicate the relative importance of these movement barriers will continue (Department of Health, Education, and Welfare, 1969).

This problem of transportation barriers is further emphasized when one considers that four-fifths of seriously disabled adults who have been judged employable by their physicians or rehabilitation agencies, and who are of working age, are unable to earn a living (Lauder, 1969).

However, it is apparent that government agencies are beginning to concern themselves with the problem of transportation and architectural barriers. The United Sates Department of Transportation is undertaking a project to identify certain barriers within the transportation system, and to take action to eliminate them. Under a federal grant the Massachusetts Institute of Technology is endeavoring to develop a 'Dial a Bus System," to be tested in two years. In developing housing of special design for physically handicapped and elderly persons with disabling conditions, HUD is giving serious consideration to location in relation to continued mobility of the group. Because a majority of residents of such housing must rely on available public transportation, the consideration of location is based primarily on the presence or absence of public transportation (President's Committee on Employment of the Handicapped).

There has recently been meaningful federal and state legislation requiring that facilities be made accessible to the physically handicapped. Public Law 90-480 passed by the 90th Congress, August 12, 1968 decrees that all federal structures as well as those financed by federal funds be made accessible to the physically handicapped. The law also stipulates that when public structures undergo extensive alteration the elimination of barriers to the handicapped be included as part of the contract.

About forty states have passed similar legislation requiring that state owned buildings be made accessible to the handicapped. Some of them along with many municipalities are adapting building codes affecting all private projects (Hillary, 1969). In 1966 the 73rd Legislature of the State of Michigan passed Act No. I of the Public Acts of 1966. This act provides for the accessibility and the utilization by the physically handicapped of public buildings constructed with funds of the state. It also covered the accessibility of parking lots, building approaches and entrances, sanitary facilities, corridor and room identification, and special rooms. It is interesting to note that from 1963 to 1968 there were 35 major laws enacted by the Congress which affect the handicapped (Department of Health, Education and Welfare, 1968). However, it is unfortunate to note that some state laws lack teeth and are still vague and weak. Although 44 states have now passed laws or taken other official actions, there is still a question whether individuals will pay attention to these laws (Health, Education, and Welfare, 1969).

However, there is an increasing number of publications and organizations reports coming out with standards and specifications for making architectural and travel facilities accessible to the physically handicapped. James Hillary, an architect, gives his interpretation of the concept of "barrier free" to simply mean a lack of obstacles. The intent is that buildings may be entered and used by all regardless of one's physical condition (Hillary, 1969).

The publication of the American Standards Association,

Specifications for Making Buildings and Facilities Accessible to, and Usable by the Physically Handicapped gives specifications for the following facilities:

1. Wheelchair specifications, and functions
2. Grading; attain level of normal entrance
3. Walks; width and slope for ease of navigation
4. Parking lots (spaces) wide enough to load and unload safely.
5. Ramps and gradients; slope and surfacing for easy use
6. Stairs; nonslip flooring for safety
7. Mirrors; mounting heights for all needs
8. Water fountains; type and mounting height for every use
9. Controls; mounting height for light switches, heat, and fire alarms
10. Warning signals; audible and visual for all needs

(National Society for Crippled Children and President's Committee on Employment for the Handicapped, 1961)

The State University Construction Fund of New York has come out with a checklist for making colleges and universities accessible to handicapped students. This architectural checklist is a guide for the use during planning, design, and construction phases of campus projects. It can be used to evaluate the accessibility of existing facilities. It offers a checklist for the following:

1. Ingres, egress, and access
   Doors, stairways, parking, elevators, walkways
2. Spaces requiring special attention
   Dormitories etc.
3. Sanitary facilities
   Toilets, stalls, sinks, mirrors, showers, dining areas, lecture halls, laboratories
4. Specialties
   Drinking fountains, light switches, electric outlets, telephones, room identification and vending machines

(President's Committee on Employment of Handicapped)

Residential and Supporting Service Needs

In evaluating housing needs for the adult physically handicapped

it becomes apparent that there is a need for construction of low cost housing facilities. There appears to be a significant housing lag for married handicapped people with children. Another pressing need is that a portion of any regular housing unit should be accessible for physically handicapped in order that they be able to mingle with individuals who are not physically handicapped. In reference to residential planning it should be understood that there are two groups of adult handicapped, independent adult handicapped and dependent adult handicapped. Each needs a different planning approach. The independent need help only as far as physical or social services are concerned, plus minimal borderline, rehabilitative services. There is a need to bridge the gap for the more severely physically handicapped. Thus, the independent physically handicapped really do not need many services outside of physical needs. They want to be able to spend some time with individuals who are not physically handicapped (Sehler, 1970). It is the independent physically handicapped that would probably benefit from the type of housing units proposed by the Michigan Housing Authority.

There is some evidence that there might be some difficulty in getting adult physically handicapped to use low cost housing. For example, the Lansing, Michigan project had difficulty in filling available space with handicapped individuals. The impression was that the problem centered about the fear of certain handicapped people to leave the protective environment of their homes. It has been suggested that any low housing program for adult physically handicapped should include counseling and experiences in how to live away from home

(Interview of Morrison).

It has been suggested that one of the best ways to get adult handicapped individuals into low cost housing is to get them involved in the projects or in some aspect of the planning. For example, such an endeavor was undertaken with some success with the Lansing Chapter of the National Association of the Physically Handicapped (NAPH). Under the leadership of the NAPH a questionnaire was formulated for physically handicapped persons who might be interested in low cost housing. Copies of this questionnaire were sent to the United Cerebral Palsy Association and to vocational rehabilitation people. Officials of the Michigan Department of Education helped to track down interested applicants, and provided transportation to the NAPH housing office in order to have the real application forms filled. This questionnaire and the resultant follow-up came up with the following observations: Many physically handicapped people have families and need a special type of housing. Another group of handicapped need some kind of subsidized housing. This questionnaire came up with other significant findings. Many of the handicapped individuals questioned wished to live in a housing facility which housed non-handicapped individuals. It was, also, advised that any housing facility which would include handicapped persons should be located near inexpensive, and safe transportation facilities and should be located near shopping centers and other facilities which might be of service to the physically handicapped (Sehler, 1970).

A Brief Description of Some Housing Programs

In the discussion of housing needs for the mentally retarded it

was observed that supporting services were the major factors in any residential program. It was suggested that any residential program should have as its goal to provide an atmosphere which, as much as possible, resembles a normal household. It is also suggested that adult physically handicapped should, as far as the physical disability dictates, be provided with an atmosphere which is non-institutional in physical appearance and philosophy and which is homelike in its appearance. Although services are important in housing for the physically handicapped, it should be understood that the non-intellectually impaired physically handicapped want services, and housing facilities only insofar as their physical needs dictate. They wish to have as much independence as possible.

It is interesting to note that the Federal Housing Acts of 1964 and 1965 have specific provisions to provide appropriate housing for handicapped persons of low and moderate incomes, at prices they can afford and which will be designed to improve their ability to live independently. As a result of this legislation, HUD has prepared a guide for state and local housing authorities, architects, and others to use in connection with low rent housing designed for the physically handicapped. Under the United States Housing Act of 1937, authorization is given to local and state agencies so that they can provide decent, safe, and sanitary housing for families that cannot afford housing available in the private market. Such housing programs may involve new construction, acquisition or rehabilitation of existing housing or leasing existing housing. In recognition of the new low incomes of the handicapped, disabled and elderly, an

additional operating subsidy of as much as $120. per dwelling unit is authorized for units so occupied when such amount is necessary to meet two objectives: rents they can afford, and a solvent project operation (United States Department of Housing and Urban Development, 1968).

California has started a comprehensive program to determine and subsidize residential programs for the physically handicapped. California Senate Bill No. 934, Section 1, Article 3.3 which authorizes the State Department of Public Health to initiate and carry out a pilot project for the purpose of determining the needs of physically handicapped persons of normal mentality for residential care and to determine how best to meet these needs (California Department of Public Health, 1964). It is important to note that residential care was used by the California State Legislature to denote not a special institution to house handicapped persons:

> ...as a state hospital houses mentally ill, but to embrace all types of services and living arrangements appropriate for individuals who are...physically handicapped, but of normal mentality.

Residential care thus included a flexible range of housing situations and determination of which care services are essential and appropriate for the well-being of the individual handicapped person.

Seattle, Washington is an example of a community undertaking an ambitious and comprehensive housing program for the adult physically handicapped, in its Center Park Housing Units. The planning stages for this program were put into affect in 1963. During the planning stages housing representatives and architects met with a committee of handi-

capped individuals to determine the needs and priorities of this project. Initial occupancy for Center Park was in November, 1969. Center Park is a 150 unit apartment building especially designed to meet the needs of the physically handicapped and to enable them to live independently. It is the first of its kind in the nation and part of a complex for the handicapped which includes the lighthouse for the blind's sheltered workshop, and will also be a service center for the handicapped and to be built and operated by the Seattle Handicapped Club (Seattle Housing Authority).

Center Park is a seven story brick structure of modified cross design and is completely barrier free, with level entrances, wide corridors, automatic outer door, covered parking, and large elevators. Apartments are well lighted by large windows and each has a concrete planter box. Each floor has a sun deck and the large concrete plaza above the parking garage is suitable for wheelchair activities such as square dancing, shuffleboard and other outdoor sports. Handicapped persons are eligible to live in Center Park providing their income does not exceed $3,300 for a single person, or $4,300 for a couple, one whom is handicapped. There is an assist limitation of $9,000 unless otherwise approved. Priority is given to persons who have an orthopedic or neurologic handicap which significantly interferes with ambulation and who thus have greater need for the special design features built into Center Park (Seattle Housing Authority).

Since 1961, New York Service for Orthopedically Handicapped has been conducting a demonstration concerned with placing moderately

and disabled adults in foster homes. To date, about 50 adults have been placed. About one-third are wheelchair bound; another third use braces or crutches to walk. About one quarter of the group work, and are partially or fully self-supporting. The remainder are programmed in the social recreational activities in the community and need full or partial assistance from the Department of Welfare. Astute and continuous social case work has been the hub of the operation. This began with careful screening of homes and matching client to home. A trial visit is part of this process. The disabled person is carefully programmed, utilizing community resources to the maximum (Helsel, 1965).

The Connecticut Program is an example of the apparent new philosophy of care in action. At the Seaside and New Haven Regional Centers there is a program which uses community facilities to the fullest extent. Law provides for free movement in and out of the residential center as needed (Helsel, 1965).

New Horizons, in New Britain, Connecticut, is an example of a residential setting for the physically handicapped which attempts to provide a normal type of residential setting. Two hundred residents live in a modern two story wing of a hospital in New Britain. These are severely handicapped individuals who have such disorders as paraplegia, cerebral palsy, polio, multiple sclerosis and birth defects (New Horizons, 1966). The ultimate goal of this program is to establish a community house and center where handicapped persons can be provided with dynamic, and productive living experiences. It is the hope that the residents can develop a spirit of self-determination

(New Horizons, 1966). The individuals connected with this program feel that the larger the residential population is the less home-like and the more like an institution the residence is apt to become. They, also, feel that people living in chronic disease residences should have a definite say in the management of their own lives, especially in regards to recreation and productive living (Macko, 1964).

Although many physically handicapped persons are still being placed in institutions, it is safe to assume that most handicapped people of normal mentality do not need, nor do they desire institutional placement. Rather, with the provision of medical supervision, attendant care, nursing, counseling, and all forms of residential care most can function well in their present independent living arrangements. For a few others, special housing, such as a protective facility may be necessary. The longer this latter solution is avoided, the happier and more independent the person, and the more economical his care (California Department of Public Health, 1964).

Mentally Ill

Non-institutional housing facilities for the mentally ill, or rehabilitated mentally ill has shown more of a lag than even the lag shown in housing for the mentally retarded or physically handicapped. Complicating this residential lag is the fact that many mentally ill persons are incorrectly placed in mental hospitals or institutions, and are receiving improper care (Group for the Advancement of Psychiatry, 1969). Although there is this obvious need for residential facilities for the mentally ill, it is apparent that such housing arrangements are to be transitory in program design. They are to be a means by which the mentally ill individual can be aided in his attempt to readjust to community living. When the emotionally disturbed adult is satisfactorally rehabilitated, he can return to an independent and normal type dwelling. Basic to the concept of transitory residential facilities for the mentally ill, is the assumption that most mentally ill individuals cannot come out of a hospital or institution and assume all the responsibilities demanded of a normal person in our society. He may have a setback. As with individuals who have received surgery, the mentally ill need a period of recuperation, rehabilitation, and decompression (Judson).

A tremendous barrier to the establishment of residential programs for the mentally ill is the knowledge that zoning laws, and public opinion are less understanding of the residential needs of the mentally ill, then even the negative attitudes of individuals

toward the mentally retarded. A recent session of the Detroit Common Council, (August 7, 1970), for the purpose of creating a zoning ordinance for the establishment of family care homes for the mentally ill provided the following observations: the ordinance was somewhat restrictive. The attitudes of some individuals residing in neighborhoods where family care homes have been established, or where they might be established, were extremely unrealistic to the needs of the mentally ill. The restrictive nature of the zoning ordinance can be seen in the following passages (Detroit Common Council, August 7, 1970):

> Land shall be made available in certain residential and commercial areas. The land made available will not include residential areas of single and double residences but rather multiple residences. Not more than one family care residence can be closer than 300 feet from one another.

During the question and answer period of the meeting, individuals from the community voiced the following types of objections:

1. Zoning laws for the mentally ill should be more restrictive. The 300 foot ruling is not restrictive enough. There should be more space between family care homes in order to prevent having two such residences on the same block.

2. Family care homes should not be built or leased in the proposedneighborhoods for at least five years.

3. Family care homes are not properly supervised. Patients roam the streets, molest women and childrer and attack the merchants.

Residential Programs

Recent residential programs for the mentally ill (of a non-institutional setting) are leaning toward foster homes, family care

situations, or other homelike dwellings such as halfway homes. The Wisconsin Department of Health gives the following definition of adult foster home care (Wisconsin Department of Health and Social Services, 1969):

> Adult foster home care is a specialized method of social care, for one or two unrelated individuals, which provides a family living environment with individualized attention to the guests' (mentally ill) social, and personal needs, when such placement is deemed to be necessary for protection and well being of the guest and an extension of the therapeutic or rehabilitation plan.

The halfway house is defined as:

> An important link in the chain of agencies serving the mentally ill.... It is conceived to be a therapeutic service for the patients who have reached the halfway mark toward resumption of independent living and who are no longer in need of the extensive service of a hospital or institution....for this reason emphasis is placed on the homelike features of the facility with residents given much the same kind of responsibility for themselves, their own homes.
>
> Family care refers to group as well as an individually oriented program which utilizes private homes in the community for placing mentally ill patients who have been previously hospitalized....Essentially, it is an extension of some hospital services, but is in the community and lacking in degree the controlled, disciplined and institutionalized nature of the hospital. (McNeely, 1969)

California has initiated a comprehensive halfway house rehabilitation program for the mentally ill. El Camino House in Belmont California is an example of such a program. It is sponsored by the Mental Health Recovery, Inc. It is a three

year project to determine to what extent a program can be developed in the community which will serve the needs of long term hospitalized mental patients coming out of the state hospitals. Recent studies suggest that the patients' experience while in the hospital has little to do with success or failure when they leave. Ability to remain out of the hospital and the level of functioning while in the community are more related to what kinds of support and resources are available after the patient has left the hospital (Goertzel).

Residents come to El Camino House after being recommended by psychiatrists, probation officers and other professionals. They are interviewed and thoroughly screened before being placed in the residence or on a waiting list. El Camino House serves men and women over eighteen. This residence operates on a high expectation concept. This is social psychology's answer to the old custodial concept under which mentally ill people were regarded simply as patient vegetables unable to assume the most routine responsibilities (Mental Health Association of San Mateo County).

The residents have keys and can come and go without curfews. They have to keep themselves and their apartments clean and are responsible for their own medication, if any. They are expected to sign up on crew lists for cooking and cleaning chores. Each resident is required to do something constructive during the day. They work, go to school, and attend psychiatric counseling sessions (Mental Health Association of San Mateo County).

Milwaukee has two family care residences for the mentally ill,

and is run somewhat on the same concepts as Milwaukee's Council House, a residence for the mentally retarded. They are Snyder and Chapman House. Snyder House is a three floor residence on the east side of Milwaukee, for women between eighteen and sixty. It has a program of living similar in some ways to El Camino House in California (Milwaukee County Association for Mental Health, 1970). Chapman House is also a residence for women. They are assisted in transition from the mental health centers or some other hospital (Milwaukee County Association for Mental Health. 1970). Its purpose is to provide a temporary home for individuals already in the community with problems of such a nature that atmosphere of a home type residence would be beneficial. Chapman House is located within walking distance of shopping areas, parks, and churches. Public transportation is convenient to all parts of the city. The staff includes such individuals as a psychiatric social worker, housework assistarts, and a part time houseman to do heavy work (Milwaukee County Association for Mental Health, 1970).

Hill House in Cleveland, Ohio is a halfway house which serves people who have been treated for mental and psychiatric problems (Mental Health and Research, Inc.). Its purpose is to help mentally ill individuals make the transition from hospital to community life. It is geared to help improve the level of personal and social adjustment in the community, and prevent the necessity for rehospitalization. The professional staff includes an executive director, two case workers, two group workers, and research personnel. This service provides a coordinated program of individual counseling, group

discussions, work projects and recreational activities.

Fountain House in New York, Horizon House in Philadelphia, and the Family Care Organization, associated with the Ypsilanti State Hospital of Michigan are more examples of non-institutional residential programs for the mentally ill. Fountain House profit corporation organized in 1948 as a pilot demonstration center in the field of psychiatric rehabilitation. Its objective is to create and provide more effective rehabilitation services to facilitate the community adjustment of psychiatric patients who have been hospitalized in mental institutions (Fountain House Foundation, 1967-68). Horizon House in Philadelphia is basically similar in its approach to Fountain House. It provides the following experiences in community living: Classes in personal hygiene, budgeting, house keeping and sex education. Group and individual counseling and work experience is provided (Horizon House).

Michigan's approach to family care is shown by the Ypsilanti's State program, sponsored by the "Family Care Sponsors" of Wayne County. This family care program is for the care, and treatment of mentally ill persons who have gained maximum benefits from hospitalization but who have not improved sufficiently to return to their homes or to independent living in the community.

III

RESULTS OF THE STUDY

In 1965 the Mental Retardation Task Force on Education, Vocational Rehabilitation, and Employment, a sub-committee of the Governor's Planning Committee on Mental Retardation, in their recommendations made several propositions intimately related to community housing for the "independent" mentally retarded. Among many suggestions for improvements for the mentally retarded they urged formal and continuing provisions for the mentally retarded adults after work hours, community centers to meet the variety of problems not being recognized in the then existing programs under education, welfare, health, mental health, etc. (Task Force, 1965). Implicit in the report was strong emphasis of the need for sheltered employment and appropriate community living facilities.

The most significant expression of the general magnitude of the concern for immediate priority of improvement of community facilities and programs for the mentally retarded was recently expressed by Harold Bergum, President of the Michigan Association for the Mentally Retarded (Focus, 1970). He stated,

> MARC is committed to the concept of small living facilities for the mentally retarded. The reasons are widely supported by experts in the field in this country and throughout the world -- the gap between our advanced knowledge and our common practice increases more rapidly. ---the architectural epidemic of medical hospital designs geared to the isolation of the retarded for the needless protection of society -- our own research

> experience and knowledge calls for a variety of services all of them geared to the community and all of them taking full cognizance of the human and civil rights of the retarded.--.
> There is no reason why retarded adults (not requiring medical service beyond those of the average Michigan community) should not live in a workshop, their recreational activities and their/ job as do other members of the community. For these reasons such residences should not be planned to accomodate larger numbers of people than is usual for other residents in the surrounding neighborhood.

Bergum's statement is accurately representative of the general evidence obtained in the study from the literature, personal interviews with experts in the field and site visits to community facilities. The present concensus is that we must get away from institutional types of settings for the competent mentally retarded and the rehabilitated mentally ill (Bergum, 1970, Bywater, 1970, Fernald, 1925, et. al.).

In this vein the study also tragically illustrates that anyone pursuing the improvement of community facilities must anticipate strong, even organized opposition, from within the community (Bywater, 1970, Detroit Common Council Meeting, 1970). Evidence was uncovered of community programs that were closed because of organized political pressure from neighborhoods.

Regardless of the reality problems that will surely be encountered the evidence is overwhelming that philosophically and economically our existing conventional institutions should be reserved for the severely mentally retarded, the profoundly mentally ill and the multiply handicapped. Also, we cannot forget that within our present institutional population are many who are there because of the problems they have encountered in the commun-

ity in their after work hours (leisure time) and improper or non-existent living opportunities. Additionally, the literature is rich with information as to the negative effects of institutional living on the eventual chances for the individual to adequately survive in the real world (Butterfield, 1967, Kirkland, 1967, NARC Policy Statement, 1968).

Consistent with the concerns set out above [illegible] study uncovered evidence, of a national nature, of beginnings of what hopefully may become a ground swell of variegated community facilities for the adult handicapped. These programs have been reviewed in detail in the review portion of the study but some additional emphasis is appropriate.

There is great and we feel desirable diversity of programs and facilities. They vary from motels that have been adapted (San Diego, California, Aurora, Illinois) to a 200 apartment 12 story building in New York City. Along this continuum are foster home programs where one or more retarded adults live with a private family, segregated programs where retarded adults are living together with supervision in a large and attractive "old" home, integrated settings where retarded are living in neighborhoods with otherwise "normal" individuals.

Within the various types of facilities the programs run from no supportive service whatsoever to well planned, high quality, comprehensive services. In some of the facilities studied recreational programs and other supportive services were only "token" (Kaplan, 1970). In many sites there was serious lack of community support and acceptance.

Only in very few programs did there seem to be well thought out commitment to the primary quartet of Independence, Vocational, Social, and Emotional Development. (Kaplan, 1970)

Reason for caution frequently surfaced relative to the dichotomy of integrated vs. segregated living for the retarded adult. On one side it seems that when the retarded adult, with perhaps very few others is installed in an integrated setting with his normal peers he is not included in their general pattern of living so the hoped for integration actually creates isolation and rejection. In spite of this the creation of independent living programs for the adult retarded is an unwholesome alternative. However, a fairly large "colony" of retarded in a facility for normals although smacking of segregation of the retarded may be a possible way to avoid extreme isolation and rejection. This isolation could work toward normality (Bolton, Sokoloff, 1970).

The concensus of evidence implies it is desirable to strike off in "brave" new ways rather than be fettered to the piecemeal and fragmented programs of the past such as foster-home care etc. Because of the isolated and piecemeal nature of most existing programs if we are to draw value from them it must be by incorporating many things from a wide spectrum of resources.

Our data indicates that the dimension of geography is crucial. Any facility/program for independent living must be near a concentration of potential employment. Jobs for the retarded are difficult to obtain and often they are the first to be laid off so this

requires high job availability as well as high quality job placement, follow-up and personal support and guidance. The facility must be very near public transportation, hospital/medical/clinic resources, recreational and diversified shopping facilities. Reasons for this concern is the pronounced uncertainty as to the economic ability and personal responsibility factors in the retarded to own private vehicles.

Location and zoning are unfortunately inseparable. Because of the nature of the handicap with which we are concerned and the sometimes inherent restriction of analytical ability, many retarded are highly susceptible to exploitation both sexually and economically by unscrupulous "normal" individuals. This dictates that a facility/program must be located in a"low risk" area. This would usually dictate against areas zoned commercial and many multiple dwelling areas. This restriction would focus a location toward more "desirable" neighborhoods where community resistance may be more apt to be encountered. This may have strong implications for extended preliminary local public education and public relations.

Selection of tenants is also crucial to the success of our program of independent living. Necessarily because of the prohibitive expense involved those individuals who would need medical care as therapy beyond normal requirements must be excluded. (Cox, 1970)

Previous screening experience would indicate that it may be possible to include in each public housing program a few units reserved for adult handicapped. The adult retarded would need only standard housing and some units would need architectural modification

for the physically handicapped (Bolton, 1970, Cox, 1970, Sokoloff, 1970).

There seems to be a general feeling that before any facility is planned the potential handicapped residents should be consulted and their thinking must be taken into consideration. The consumer should be consulted in any planning (Bolton-Sokoloff, 1970). Additionally, the handicapped residents should take some responsibility for and in the management of the facility/program (Bywater, 1970).

It would be redundant to give extensive consideration here to the architectural/construction dimension of the study although the study team gave this area substantial attention. The appendices of this document includes a supplemental report from a very specially qualified consulting organization who have given considerable attention to the unique architectural challenges involved. (Bolton and Sokoloff, 1970) In addition, the bibliography and, library that accompany the study provide extensive resources on architecture and physical planning of a facility.

However, some general architectural priorities permeate the total planning requirement. It is very evident that the architect must sit in from the very beginning on any planning of a structure for the handicapped. The consultant must have the technical as well as philosophical knowledge relative to the handicap/handicaps involved. This is crucial because any facility must reflect the new ideas and philosophies related to the handicapped. He must be oriented to the total life needs of the handicapped person and these

cannot be met by just an attractive conventional structure of brick and mortar. There must be beauty but the cosmetic priority must be based upon and planned around the total program of service for the handicapped.

IV

SUMMARY AND RECOMMENDATIONS

The general motivation for this study/survey grew out of a desire on the part of the Michigan State Housing Development Authority to gain information for the possible construction of innovative community housing for the adult handicapped. It was assumed that a survey of the related literature and careful examination of existing facilities would yield information necessary for planning such housing.

The project has determined that there is desperate need for extensive facilities for the adult independent handicapped in all communities in Michigan and throughout the nation. Concurrent with the recognition and definition of need is a waxing overall philosophy of support for such programs. The support and interest of parents, the handicapped themselves, and concerned citizens is no longer academic but rather it is strong and organized.

During the survey it was determined that isolated and varied programs are developing to meet this need but they are piecemeal, often isolated and inadequate in light of the magnitude of the problem. Also the assumption that classical institutional programs, on the one hand and community educational programs on the other, are adequate to meet the problems of the handicapped is no longer defensible.

Additionally, it seems that Michigan has an opportunity to innovatively pioneer one possible solution in the area of public housing that could provide a pattern and a direction for the entire community.

RECOMMENDATIONS

The evidence obtained over the life of the study seems to warrant the following tentative recommendations for public housing for the adult handicapped:

1. That public housing be constructed immediately to demonstrate the feasability, proven elsewhere, of the adult handicapped living "independently" in the community.

2. A committee should be appointed made up of representatives of interest groups for the handicapped as well as top level representatives of appropriate state agencies. This committee should consider carefully all of the information supplied in this study with primary concern for rapid implementation.

3. Ideally, eventually a master agency or council should be created with the primary charge to coordinate and create a diversity of types of housing and service for the handicapped throughout the State of Michigan.

4. This master council would, as a continuing body, provide the coordination of supportive services so vitally necessary to a successful housing program.

5. The council must provide specific resources necessary for success such as application, screening, and orientation of applicants. It was apparent early in the study that persons with serious histories of delinquency or severe physical handicaps, in addition to mental retardation, did not make good risks. Also, the need for a good preparation/orientation programs for the tenants was vital.

6. The facility must avoid adopting individuals from the community who give evidence of already "making it" independently.

7. However, the housing should provide for those already in the community where housing is crucial to their success as well as for those returning from a more institutionalized kind of setting.

8. The evaluation process must also determine if the person is "prepared" for productive participation in the community and that he has a job with an approved employer. This does not mean that individuals working in sheltered setting should be excluded if their financial resources can support the financial obligation that is implicit.

9. The location of the facility must be carefully chosen to provide easy transportation, adequate recreation, appropriate medical service, shopping facilities and job opportunities.

10. The high exploitation factor of the mentally retarded and the recuperating mentally ill must be considered.

11. The sponsoring authority will need to contact existing associations and societies in order to recruit sponsoring non-profit groups. The study points out that already existing groups such as the local association for the retarded, emotionally disturbed and physically disabled are excellent targets.

12. There is a prevailing view that it is more desirable for public agencies to furnish services and finances to the sponsoring groups rather than for the state to directly provide facilities and programs.

13. Physically handicapped adults do not like to be completely segregated. Therefore, they should be placed in a housing situation which would enable them to be near nonphysically handicapped individuals.

14. The handicapped should be permitted to have a voice in the design, planning, and management of any housing facility in which they may reside.

15. Any residence for the physically handicapped should be so designed that all entrances, exits, furniture, utensils, and facilities should be so constructed that they may be accessible and usable.

16. Physically handicapped seem to be most concerned about the design of the bathroom. The bathroom should be large enough to accomodate a wheelchair. There should be bars on each side of the toilet bowl to enable an individual to hold on, or help seat or raise himself.

17. All floors should be carpeted in order to avoid the danger of slipping. Folding doors are advised. Kitchen cupboards should be low enough for an individual in a wheelchair to reach items. All control devices, i.e.: light switches, stove switches, warning systems, elevator buttons should be low enough to be reached by individuals in wheelchairs. Also, bathrooms and kitchen sinks should be so constructed in order to be reached by wheelchair individuals.

18. There should be entrances void of curbs or steps with appropriate ramps for wheelchair individuals.

19. There should be some sort of elevator controls (i.e. braile) to enable blind or partially seeing individuals to use them.

20. Any housing program for the mentally retarded should be planned to give as "normal" a homelike situation as the degree of retardation dictates. Over-dependency should be discouraged. We strongly recommend a regional or zoning approach similar to the one used by Illinois in designing programs and housing facilities for the retarded. The State of Illinois is divided into eight planning regions. Programs are designed according to the peculiar demographic, geographical, and living patterns of a particular region. For example, the retarded individual's experience in a rural setting is different than his experience would be in a heavily populated urban complex. Housing programs for the mentally retarded should be designed with these differences in mind.

21. We strongly favor smaller housing units for the mentally retarded. A 400 or 500 room apartment building should not be totally inhabited by retarded individuals. This would reinforce feelings of inadequacy or abnormality. However, we would not be against having retarded people living in a large structure also inhabited with "normal" individuals, or some physically handicapped.

22. Housing programs designed specifically for the mentally retarded should not have more than fifteen in any one residential type of dwelling.

23. Programs for the mentally ill should be designed to bridge the gap between the mental hospital and community life. Thus, housing programs for the mentally ill are to be transitory in nature. As in the case of the mentally retarded, supporting services i.e. psychiatric follow-up, experiences in normal living, are more crucial than the actual housing facilities.

24. All programs surveyed reflected the importance of the wide and wise use of volunteer groups. Also "live in" personnel is vital for assistance in emergencies. This might be a man and wife, paid college student, etc.

With the vast accumulation of evidence of similarities as well as differences that emerged from the study, the one thing that is certain is that much greater immediate effort is justified to create quality public housing programs for the adult handicapped. The problem of housing for competent handicapped individuals in our communities is much more a matter of individual as well as collective responsibility than has been previously recognized or admitted.

APPENDICES

APPENDIX I

LIST OF AGENCIES CONTACTED FOR

ADULT PHYSICALLY HANDICAPPED PROPOSALS

1. Detroit Cerebral Palsy Center, 10 Peterboro Avenue, Detroit, Michigan. Mrs. Margaret Schilling, Executive Director, August 10, 1970 Interview.

   This agency provides a comprehensive program of vocational training, and residential placement for cerebral palsied, and other handicapped individuals.

2. Division of Mental Retardation Services, Illinois Department of Mental Health. William Sloan, Ph.D., Director, Springfield, Illinois, August 14, 1970 Interview.

   This Division provides a comprehensive program of generic, and supportive services for the mentally retarded. It has divided the State of Illinois into eight zones or regions in an attempt to formulate educational, vocational and residential programs for the mentally retarded.

3. Jewish Vocational Services, Milwaukee, Wisconsin, 207 E. Buffalo, August 7, 1970 Interview with Mrs. Patricia Malnekoff.

   This agency offers one of the most comprehensive programs of generic services, and supporting services for the mentally retarded, and mentally ill in the United States. They offer varying degrees of job training, and sheltered workshop skills. They have a chefs program for mentally retarded, and a rehabilitative program for mentally ill coming out of the state hospitals. The Council of Jewish Women, a branch of the Jewish Vocational Services, is involved in programs providing foster homes, halfway houses, family care services, and normal type residential situations for the mentally ill, and mentally retarded, Council House (of Milwaukee) is a nationally known residential program for the mentally retarded (sponsored by the Milwaukee Council of Jewish Women.)

4. Division of Special Education, Michigan Department of Education, Lansing, Michigan. Director, Dr. Arselia Sehler, Interview of August 13, 1970.

   This Division cooperates with the state universities and colleges in certifying special education teachers,

and vocational rehabilitation workers. It is also highly involved in residential placement and generic services for the adult physically handicapped.

5. Michigan Department of Mental Health, Division of Mental Retardation, Director, Mr. Michael Kreider, Lansing, Michigan, Interview of August 6, 1970.

   This agency is involved in determining constructing and funding educational and vocational programs for the mentally retarded. It is constantly doing scholarly research into the area of mental retardation and this division also works closely with the state universities and colleges of education in determining teacher certification standards. This division is extremely interested in housing facilities as well as supporting services for the menta ly ill.

6. Michigan Society for Crippled Children and Adults, Robert Cox, Director, 10601 Puritan Avenue, Detroit, Michigan. Interview of July 14, 1970.

   This agency is interested in providing vocational, and rehabilitative services for the physically handicapped.

7. New Horizons, Farmington, Michigan, Mrs. Wagner and Mr. Benike interviewed August 4, 1970.

   This organization is providing normal type dwellings and supporting services for the mentally retarded in Farmington, Michigan. Wagner House, a ressidence for the mentally retarded is associated with New Horizons. This organization favors the smaller type residential facilities for the mentally retarded.

8. Plymouth State Hospital and Training School, Division of Mental Retardation, Mr. George Ebling Jr., Director, Northville, Michigan. Interviewed August 3, 1970.

   This division is engaged in an educational, vocational training and job placement services for the mentally retarded. Although this division has resident mentally retarded, its staff is attempting to evaluate possible non-institutional residential programs for the mentally retarded. It is also involved in influencing communities to pass zoning laws which are more realistic to the residential needs of the mentally retarded.

9. Sokoloff-Hamilton-Blewitt AIA, Architects and Planners, San Francisco, California, Arthur Bolton Associates, Sacramento California. August 24, 1970 interview with David Sokoloff,

and Arthur Bolton of the above architectural firms at the Michigan Housing Commission Offices, Lansing, Michigan.

These two firms have been involved in designing and constructing residential facilities for the mentally retarded, and physically handicapped. Mr. Sokoloff's firm has also designed barrier free facilities for the physically handicapped in Sacramento.
Mr. Sokoloff has provided us with a comprehensive series of recommendations for our proposals for the Housing for the Adult Handicapped in Michigan. (Michigan Housing Commission)

10. United Cerebral Palsy Association of Michigan, Directors, Roy Morrison and Robert Mayberry, 202 E. Boulevard Drive, Community Services Building, Flint, Michigan. Interviewed July 17, 1970.

This agency is concerned with providing generic services for cerebral palsied individuals. It is also involved in vocational training and institutional or residential placement for the physically handicapped.

11. Ypsilanti State Hospital, Detroit Unit, Cadillac Square Building, Detroit, Michigan, Mr. Leroy Bywaters, Psychiatric Social Worker.

This agency is involved in vocational training and rehabilitative services for the mentally ill. Part of its program is a comprehensive placement procedure for individuals into institutions, halfway homes, foster homes, and family care residences. An extensive out-patient therapy program is provided for its clients.

Interview of Mr. Arthur Bolton and H. David Sokoloff, AIA, by Milton Hyman, August 24, 1970.

Mr. Sokoloff and Mr. Bolton are architects and have designed residential and classroom facilities for the mentally retarded. Mr. Bolton is head of Arthur Bolton Associates, 1731 I Street, Sacramento, California 95814, and Mr. Sokoloff is associated with Sokoloff, Hamilton, Blewitt AIA, Architects and Planners, 244 Kearny Street, San Francisco, California, 94108. Mr. Sokoloff is president of California's Association for the Mentally Retarded. He was consultant for four years on the State Advisory Hospital Council and has also been a consultant for the Department of Health, Education, and Welfare.

Both Mr. Bolton and Mr. Sokoloff believe that educable mentally retarded can live in standard apartments, and when they are placed in such residences a variety of support alternatives should be tested. They believe in this rule of thumb. That in housing the mentally retarded we should strive for normality. They should have a minimum degree of isolation and that the maximum degree of normality should be tested. Certain couples will need more support and others will need less. These programs should be followed by careful observation. Since mentally retarded individuals show a wide range of abilities, they will need a wide and diversified range of supporting services. They felt that initially the Housing for the Adult Handicapped units could serve as demonstration units or models. Supporting services could be assumed by any agency. This could be demonstrated in a variety of ways and housing could be implemented for the mentally retarded and physically handicapped. Some mentally retarded may work at a sheltered workshop during the day and because they can manage the rent live in an apartment house down the street. Both gentlemen felt that borderline and mild retardates do not need unique housing.

Essentially they believe that the programs or supporting agencies are the most crucial factor in housing for the mild and educable retarded. These supporting agencies, as emphasized before, should strive to establish as much independence and normal living conditions as is possible for these retarded individuals. Thus, the supporting agencies should not always cater to their dependency needs. Some programs and residences for the mentally retarded, unfortunately, make them more dependent. It is important to find out how they are functioning with minimal or extensive supports.

The California program for the retarded attempts to build in a self-fulfilling prophecy of success situations with each retarded individual. For example, California and New York State both have populations of about 20,000,000. California has 12,000 mentally retarded individuals in institutional residences and is attempting to decrease the number. New York which appears to have a different outlook has 26,000 retarded who are institutionalized and are building more institutions. In California, it is the view that one should not depend on institutions for the mentally retarded. They have designed a variety of residential alternatives such as day care centers, halfway houses, and more conventional residences. Thus, Mr. Sokoloff and Mr. Bolton feel that Michigan should limit institutional care to the severely retarded and severely retarded with multiple physical handicaps.

Mr. Sokoloff referred to several classrooms which he designed for the mentally retarded. These were very modern facilities. In one classroom an elderly lady teacher was having an extremely difficult time managing the class and seemed oppressed by these modern facilities. The glass doors were too difficult for her to open and the door tracks were filthy.

Next door was a classroom in which a black male of 22 was the teacher. He had no difficulty with the class. He used the children to help clean the room. Thus, the teacher is the key in a classroom and the people or supporting agencies who help run residences for the handicapped are the crucial factors.

Both Mr. Sokoloff and Mr. Bolton believe that any planning for housing for the adult handicapped should have some involvement of the consumers.

Summary of interview with Mr. Leroy Bywaters, Director of Social Services, Detroit Unit, Ypsilanti State Hospital, Cadillac Square Building, Detroit, Michigan.

Mr. Bywaters mentioned the following sources which he felt would be helpful to our project.

1. Greenblatt, Milton. Mental Patients In Transition.

2. Landy, David and Greenblatt, Milton. Halfway House.

3. U.S. Department of Health Education and Welfare - Vocational Rehabilitation Administration.

4. Community Placement Manual - Michigan Department of Mental Health. (We might have this, if we do not, I will ask Jim Roberts to pick up a manual in Lansing.)

5. The Common Council is Meeting on Friday, August 7, at 10:00 A.M. to discuss housing for the mentally ill and mentally retarded. I will be in Milwaukee on that day. Perhaps Sandy Shwartz could attend that meeting.

Mr. Bywaters stated the Ypsilanti State Hospital has twenty-two family care units for the mentally ill under its supervision. These patients are in the transitional stage.

Mr. Bywaters feels that we should get away from institutional type settings in respect to housing adult handicapped, especially for the mentally retarded and rehabilitated mentally ill. He mentioned a halfway house on Virginia Park in Detroit which was closed for political reasons. This housing unit had mentally ill individuals and then their presence became strongly resented by the people in the neighborhood.

In these housing units the Ypsilanti State Hospital paid the landlords up to $4.55 a day for room and board. In the halfway house situation the philosophy of Mr. Bywaters is that the residents should take some responsibility in its management. This could prepare them to live in more permanent units such as housing for the adult handicapped.

Mr. Bywaters mentioned that he hoped that the proposed housing units would not resemble sterile, hospital-like or modern square shaped structures. He mentioned several housing facilities that used old brownstone structures, and he stated that when new structures were built they included the flavor (somewhat) of these old structures in order to avoid structures resembling institutions. He suggested that I contact the following housing units:

1. Fountain House Foundation, New York, New York.
2. Horizon House, Philadelphia, Pennsylvania.
3. Hill house, Cleveland, Ohio
4. Milmet and Rulland Houses, Boston, Massachusetts

Mr. Bywaters mentioned (as others have) that getting employers to give people with a history of mental handicaps jobs has been extremely difficult. The Ypsilanti State Hospital has trained some of its rehabilitated mentally ill to work at such places as the White Castile restaurants. As their job

performances improve their pay is increased and they are placed in other restaurants.

Mr. Bywaters said that these patients are aware of the discrimination that many people have against them. He claims that when public announcement is made of our housing projects little mention should be made that there are people with mental problems in the units until after six months or a year. This should be done to show that these people are not dangerous to have in a neighborhood.

Mr. Bywaters would like to see some situations where college students in social work could help manage some units for the adult handicapped and get course credit, and room and board for their efforts (see Filmet and Rulland Houses, Boston, Massachusetts).

He suggested that I contact Miss J. Lewis Department of Social Services, 660 Temple, Detroit, Michigan. Miss Lewis, along with Mr. Bywaters are on the advisory board to the project for County Home Units. He has lent us some research materials concerning residential care for the mentally ill.

Notes taken from the tape recording of the Detroit Common Council Meeting of Friday, August 7, 1970 - Ordinance for the Establishment of Family Care Homes and Room and Board Facilities.

Part I, Ordinance

At the request of the Chairman, a physician from the Department of Health gave the following definition of the "Ordinance of Family Care," -"are individuals from state hospitals home and training schools, and similar public and private institutions who temporarily reside with an unrelated adult and whose care, training and supervision does not include medical care and therapy."

Part II, Ordinance

Land shall be made available in certain residential and commercial areas. The land made available would not include residential areas of single and double residences but rather multiple residences. Not more than one family care residence would be closer than 300 feet from one another. The residents of such areas are to be notified and the regulation of family care homes must comply with the Department of Health, and Department of safety and engineering. Such homes are not to be contrary to the Ordinance or injurious to the area. These family care homes would house mentally disturbed individuals from state institutions who are ready to be admitted into society but who need a protective environment to adjust to the community.

The ordinance also suggests the possibility of establishing room and board homes which are defined as "any dwelling housing two or more persons receiving room and board paid by federal, state, local government, or provided by an unrelated adult or adults."

The physician from the Department of Health suggested that the section of the ordinance referring to room and board dwellings as "paid by federal state, and local governments" to read any dwelling in which two or more persons live"--in order not to discriminate against those people who are subsidized versus those who pay out of their own pocket. It is important that these residences should be carefully investigated because the Department of Health is primarily concerned with (1) patients (2) possible abuse (3) exploitation (4) application of program (5) fee schedule -- which does not include services for five persons or less. In residences of six persons or more the fee runs from one dollar to fifty dollars per year. This cost the city about $25,000. The Board of Health is allowed to establish standards for family care homes, Room and Board homes etc.

Rules and Regulations - (Judgmental by Board of Health) pertain to:

A minimum of fifty square feet of bedroom space (for 2 beds) to increase to sixty feet by July 1, 1973.

DISCUSSION AT MEETING

Speaker No. I: Psychiatrist at Pontiac State Hospital, involved the last three years in the family care at that institution.

He is concerned with the lack of importance attached to family care philosophy. He feels there is a great need for family care residence. He does not think the zoning laws which threaten the establishment of family care homes. He informed the council that a good percentage of patients in state hospitals are released to family care programs. If it were not for family care programs it would be impossible or very difficult for some people to leave the state hospital system. Zoning laws are needed which will realistically provide for family care homes.

Council - to Psychiatrist:
Agrees that there is a need for such homes but too many of them in the same area could change the character of a neighborhood. For example, the area North of the Fisher building has many family care homes.

The Psychiatrist:
Did not feel family care homes could change the character of an area.

Speaker No. 2: Lady, Address: 1540 Longfellow
Stated that she runs a successful family care home for girls. They have made progress and are no trouble to the neighborhood. These girls are working, earning their own support.

Speaker No. 3: George Ebling Jr., Plymouth State Hospital
He stated that he was not satisfied with the zoning portion of the ordinance. Unfortunately, the remainder of Mr. Ebling's comment was not on the tape.

Speaker No. 4: Lee Wallace, Michigan Department of Mental Health
He stated that he agrees with the Ordinance in the respect that family care homes are needed and that standards should be set. He was pleased with the Ordinance's requirement of adequate safety and heating. However, he stated that the Department of Mental Health takes exception to the zoning provisions of the Ordinance - which permit family care homes in a restricted area (commercial and multiple residential areas) - this means virtually no extension, and amounts to a cutback in programs. He also felt that the provisions stating that such homes should be at least 300 feet apart is also restrictive. The area proposed is too limited. Mr. Wallace appealed to the Council in regard to those persons returning to the community from state institutions. They have a moral and civil right to return to society and live as comfortably as other citizens. The zoning law does not take into consideration disabilities which are not under their control.

Speaker No. 6: Priest, Representing SHARE (Self-Help Addiction Rehabilitation)
He wanted to know if the Ordinance covered such agencies as the one he represents. The Council answered in the affirmative. He felt that the Ordinance might conflict with his agency because

a strict interpretation forbids family care agencies to provide for therapy. His agency provides group therapy in order to prepare the patients to take care of their own domestic needs.

The remaining speakers appeared to represent a sizable portion of the audience opposed to the establishment of new family care homes.

Speaker No. 7: Gentleman - Representing the New Center Association - Read the following proposals to the Council:

1. Zoning laws should be more restrictive.
2. 300 feet ruling is not restrictive enough. There should be more space between family care homes in order to prevent having two such homes on the same block.
3. Limit the number of people who can reside in such homes to four or five or less. More could have a harmful affect in the neighborhood.
4. These family care homes should be in the same area where there are church and recreational facilities. The New Civic Center Area lacks in such facilities.
5. Experience has shown (according to the speaker) that the city has been negligent in enforcing regulations pertaining to environmental conditions in the area. Thus, the city would probably no negligent in enforcing regulations in regard to family care centers.
6. The New Civic Center Association does not want new family care homes in the area for at least five years.
7. The New Civic Center Association realizes the need for more family care homes (laughter from the gallery.)

Speaker No. 8: Lady Representing the Block Club - 800 Block Hazelwood and Gladstone

She believed these homes were to be in commercial areas, and not in areas of single dwellings. Her street has mostly single dwellings. There is a family care home on her block. She claims it is composed of elderly people who are let loose in the area and are poorly supervised (danger of being hurt by traffic and area toughs). The people running the home, she feels, are not qualified. She feels these patients confiict with the rights of the other people in the area. She doesn't mind supervised children in a family care home. The elderly are not welcome in her neighborhood unless some changes are made.

Speaker No. 9: Gentleman: Vice-President of the New Center Association

1. Feels there are too many family care homes in his area.
2. Homes are not properly supervised.
3. Patients roam the streets.
4. Drink, molest women and children and attack the merchants.

One of the councilman asked whether these acts were rumor or fact in order to get a proper assessment of the problem.Many angry voices in the audience shouted these acts were fact (applause etc.).

Interview of Robert Cox, Executive Director, Michigan Society for Crippled Children and Adults, 10601 Puritan Avenue, by Milton Hyman, July 14, 1970.

Mr. Cox felt that the Units should be constructed in such a manner that physically handicapped people could get along in them. He suggested that these Units should be built with wider doors and larger bathrooms. Kitchen facilities should be constructed at a lower level in order that they could be reached by people in wheelchairs.

He also felt that very little has been done in the area of low income housing. A segment of such housing could be provided for adult handicapped people.

He made reference to a Michigan State Law passed in 1966. This law states that all public buildings should be constructed to accomodate handicapped people (especially those in wheelchairs). He mentioned an amendment to this bill was passed in the Michigan State House of Representatives by a vote of 92-0. This amendment will be voted upon in the State Senate which convenes in August of 1970. This amendment proposes that all buildings (even department stores) in public use should be constructed to accomodate the handicapped. Mr. Cox was kind enough to send a copy of the bill.

Summary of Interview with Mr. George Ebling, Plymouth State Training School, Hospital and Administration Building, July 31, 1970.

Mr. Ebling is Chairman of the Regional Inter-Agency Committee (Wayne County Residential Care Committee) which is concerned with residential facilities for the mentally retarded.

Mr. Ebling stated that foster types of care have been provided in private facilities in the Detroit metropolitan area for the mentally retarded but they have not been too successful. He feels that housing for adult mentally retarded is urgent but such housing is confronted by the following problems:

1. Zoning laws
2. Cost of land
3. Determining needs

I Zoning

Mr. Ebling contacted twenty-six communities in Wayne County in order to find out if their zoning laws could accomodate multiple housing for the mentally retarded and received negative responses from these areas. He felt that there is a fear of the mentally retarded in many urban areas and he gives further examples: There was a discussion of the mentally retarded in the Boston Blvd. - Edison and Sherwood Forest areas of Detroit. The residents (affluent blacks and whites) turned down such an idea. They were afraid that mentally retarded individuals would be involved in petty crime and would so constitute a danger in their neighborhoods.

The Dearborn Association for the Retarded wanted to establish some units in an abandoned elementary school building located on five acres of land in Dearborn, however, they could not get by the Dearborn Zoning Board.

II Cost of Land

Mr. Ebling feels that housing for the adult mentally handicapped should be located in areas where these individuals have been raised. He believes that transferring them other areas would constitute too much of a new learning situation. However, he warned that land costs in urban and suburban areas are extremely high. For example, urban renewal land is selling for $175,000 an acre in the Woodward corridor area but this is a good area because jobs and transportation are available. According to the Detroit City Planning Commission a 50 x 122 foot lot in more deteriorated neighborhoods but near the central city sells for about $30,000. Eight lots were priced on an average basis in some of Detroit's inner city areas and the average was $21,000 an acre.

III Determining Needs

Mr. Ebling feels that it will be difficult to pin down or find mentally retarded individuals to put in housing units. He gives the example of mentally retarded individuals (over 21) who are on the waiting list to enter the Wayne County Training School. Their parents are elderly people who can no longer take care of their mentally retarded children. Mr. Ebling states that there are many more retarded individuals not on any

waiting list that need housing. He feels that since these individuals were raised in the city, institutional housing is the worst possible situation for them. He claims that these individuals need housing outside of an institution and that housing is only one part of the care retarded individuals need. He feels that any housing for the mentally retarded will need help from supporting agencies and that transportation and vocational facilities will have to be of primary consideration. He mentioned that mentally retarded individuals referred to halfway houses were employed on a contractual basis at the Plymouth State Training School and were provided with residential services. It was discovered that all such of services had to be provided in terms of recreational facilities, vocational counseling and advice on general grooming.

Interview with Michael Kreider, Coordinator, Lewis Cass Building, Lansing, Michigan, by Milton Hyman on August 6, 1970.

Mr. Kreider felt that supporting services for the mentally retarded and aged may be similar. He gave the example of his father who lived to be 86, the aged are more frail, like MR and need supporting service facilities (TV dinners etc.).

For housing, one must define and identify class of retarded. A physically handicapped person can also be classified as mentally retarded. An example is a 25 year trainable MR in a wheelchair who needs a sheltered workshop and lack of architectural barriers. Also, one needs a separate approach for MR and mentally ill.

Housing Needs and Housing Location

1. How it affects transportation
2. Must identify architectural barriers
3. Relates to convenience to market. Is their refrigerator enough or must they go to a restaurant?

He cited his 1962 visit of 4 months to Holland and Scandinavia. It is easier for MR to live in apartments in cities like Amsterdam than in Detroit. In Europe people are more used to buying food every day while in the US much of marketing is done once a week (which is more difficult for MR). In Europe people shop every morning and food is prepared in small packets whereas in the US it is more complex and packaging is in larger measures.

In the US gadgets are used to replace people. Europe is different. Every railroad crossing uses a watchman rather than a gadget.

Problems in Michigan

How do we get mentally retarded people out of Lapeer, Plymouth and Hawthorne who were sent there years ago and integrate them socially back into the community? For housing we are dealing with a group of people with many classifications. They have been dehumanized in the institutions. Halfwayhouse: We should re-define its function as a housing unit and its supporting agencies. We must examine a person's institutionalized hangups the same as a person out of prison.

Other Housing Facilities

Example: An individual who is just out of special class in Detroit. He is fairly prepared but parents want him to leave. This is a different situation than a child in a state home or training school who is twenty-one years old and has been in the institution ten years. He may be as smart but cannot function as well.

Where to begin?

Begin with groups of people that need services, then you might need as many different housing arrangements as in Lansing. Also, there are very few architectural designs that can be served as models for MR housing.

We must re- lucate the public if we are to do the job in education. Th. ,ublic must accept the fact that these individuals are retarded but that they still have dignity. Also, we do not have to make it convenient for society.

Hague Holland

Mr. Kreider talked about the sheltered workshop he visited in Hague. It had 25 men and 25 women manufacturing items. Twelve young women, 20-35 lived in apartments. Two women supervised this operation and came in on 12 hour shifts. Even though they served as substitute parents, they did not make the twelve women more dependent. Thus, these MR need supporting services to teach MR such things as - you don't buy 10 pounds of beef if you only have room for 5 pounds. Grooming is also important. Holland has had special education since 1910.

Mr. Kreider feels that we should investigate what types of programs can be used as models in order to prevent errors. In many instances, individuals want to come up with answers too quickly.

Mr. Kreider feels that MR services should come from the same source as normal programs. For example, MR individuals play in the regular playground. They need the same feelings of fellowship as do normal individuals. We need to work with agencies like the Detroit Parks and Recreation. They have done fairly well with the MR. Retardation doesn't have to be a handicap. Define the problem for MR housing.

Interview of Mrs. Patricia Malnekoff, Jewish Vocational Services, 207 E. Buffalo, Milwaukee, Wisconsin, by Milton Hyman on August 7, 1970.

The Jewish Vocational Service of Milwaukee Wisconsin has a comprehensive work adjustment training program for physically handicapped, mentally retarded and emotionally disturbed. This service is also connected with the Milwaukee Council of Jewish women who are supervising a series of residences for the mentally retarded in Milwaukee. All of the residences of Council House have received some training in the work adjustment program of the Jewish Vocational program of Milwaukee. A brief description of this program is beneficial before giving the actual description of Council House. This is supplemental notes to the literature given to me by Mrs. Malnekoff.

The work adjustment program services all types of handicaps. The goal is to, if possible, work individuals up to the shop. In one project MR individuals were making fancy straws for MacDonald's Restaurants. During the first few weeks an individual comes to the Jewish vocational service he is put into an assessment shop where he is evaluated and given psychological tests to determine what shop is needed for him. They also have a school work service program which aids underprivileged adolescents and gives them vocational service at many levels of competency. They make upholstery, repair small appliances, motors, etc.

Also, they have an extensive program for trainable and educable retarded youngsters which is based on the concept of operant conditioning Dr. Stratton of the Milwaukee branch of the University of Wisconsin heads this program. A system of teaching machines is used and trainable MR people have learned two words in one hour and have retained them after two weeks. The purpose of this program is to identify and develop systems under which the mentally retarded can learn and work. A system of rewards or reinforcers is instituted. For example, a group of trainable mentally retarded is given 25 seconds to put some nuts and bolts into a plastic bag. An alarm rings after 25 seconds. In terms of the signal and avoidance schedule the youngsters are paid for work produced. They are paid less if bags are lost.

Dr. Stratton is also attempting to learn how to control stability for the mentally retarded. He has developed a Skinner box for retardates. In this box the retarded youngster pressed keys based upon a certain time limit. There are four reinforcers: automatic M&M reinforcers, tokens, screen-visual reinforcers, and earphones (auditory). The experimenter can control these reinforcers and some of these youngsters will work for 2 1/2 hours. Dr. Stratton feels that individuals with short attention spans require more immediate and concrete reinforcers than normal individuals. There is a store provided for the mentally retarded individuals where they may spend their tokens on candy, costume jewelry and use a pinball machine.

On the higher level workshops, Dr. Stratton has found that the big problem with the mentally retarded is lack of confidence. If a system of reinforcers is built in the mentally retarded, they can be taught to work under tougher conditions. Going upstairs to a higher shop is a type of graduation. Thus, Dr. Stratton's project is designed to show employers under what conditions the mentally retarded can work. The problem is motivation and employers must learn how to reinforce the mentally retarded. He feels that the hard care unemployed should be handled with the same philosophy. For example, what changes of contingencies will keep them on their jobs? In certain situations: credit cards, status.

The Jewish Vocational Service also has a job sight program and a comprehensive staff follow-up. They have model apartments where individuals learn to cook, launder, etc. and a chef and cafeteria program run by professional chefs where these young adults learn to be chefs, dishwashers and waiters. Thiswriter had delicious lobster prepared by the mentally retarded youngsters.

Council House

This is a residential program for mentally retarded sponsored by the Milwaukee Council of Jewish Women. They believe there is great need for group living for the mentally retarded in order for them to be entegrated into society and become part andfunction in society. There funds are limited and they have renovated two old homes on 2003-2007 West Kebourn Avenue.

Phase I

Has one house for females and one for males and is supervised 24 hours per day. The staff of the Council of Jewish Women Services supervised this house. There are 7 males and 7 females. This is feared toward certain client prognosis for living and jobs.

Phase II

The Council of Jewish Women rented a duplex. In this phase there is minimal supervision. The Housemother and Housefather comes in three or four times a week as do the other supporting staff. In Phase II different types of individuals are tried. Sometimes mentally retarded is mixed with physically handicapped (having good abilities). There is a problem. It appears that the physically handicapped do not like living with the mentally retarded. Most of the people in Phase II should be working in a competitive situation. There is no definite time limit in which an individual should remain in a specific phase.

Phase III

In this phase the clients live together and pool their financial resources. There is no supervision but there are supporting services. There are three girls and two boys. One of the girls is a C. P. who was in a nursing home

for 12 years. She cannot live alone or work and is living with two mentally retarded girls. The rent is $105. per month and food runs about $18. per week.

Expenses

The Housemother and father get $450 a month. A student assistant (a college girl) gets $300 a month. Food bills for both houses runs about $400 a month. Both the boys and girls eat together (fifteen people at the evening meal).

Problems are the same as in a normal situation. How to get along with one another. Outside social contacts - not to get involved with undesirable social relationships. Grooming is also a problem. Other things they work with is handling of money, vocational problems, motivation, acceptance of others, close job follow-ups. These people are succeeding because of the supporting services. Each client gets individual attention. Concentration on needs of client rather than physical building, and less concentration on profit. A fear of client getting in trouble and guarding him day and night could prevent him from getting independent. Some of the supporting services and instruction and training of Council house clients are:

1. Laundering
2. Cooking classes
3. Banking and shopping
4. Tutoring by college and high school students
5. Vocational classes in sewing, woodworking
6. Speech therapy
7. Recreational facilities
8. Jewish Center has a Saturday program
9. Monday nights is for group counseling, talk about problems, speaking, police, fire department, sex education.

In the girls house five out of seven work. Two are training at the Jewish Vocational Service. Five of the boys work in competitive employment. They are allowed to have visitors and during the week must come in at a respectable time. Clients who have shown competency are given keys in Phase II.

Mrs. Malnekoff feels that there should be a Central Residential Center in large cities for the mentally retarded. Evaluations and psychological testing could be provided in such centers. She spoke about standards for private agencies helping the mentally retarded.

1. Outline minimal requirements for building codes and staff.
2. Define services rendered by professional staff.
3. Establish a quality control body to regulate utilities of private enterprises to public facilities.
4. An accreditation system.
5. A system to reflect state standards of welfare of the mentally retarded.

She urged more participation of appropriate supporting agencies. She would like to see private residential facilities assume a greater role in state, regional and national planning.

Interview of Dr. A. B. Sehler, Special Education consultant, Michigan Department of Education, Lansing, Michigan 48902, by Milton Hyman, August 13, 1970.

Dr. Sehler said there is a housing lag for married handicapped people with children. One problem is that a portion of any regular housing unit should be accessible for physically handicapped in order that they be able to mingle with regular families. There are two groups of adult handicapped (1) independent adult handicapped and (2) dependent adult handicapped. Each needs a different planning approach. Independent: Need help only as far as physcial or social services are concerned plus minimal borderline, rehabilitational aid. There is a need to bridge the gap for the more severely physically handicapped. The independent really do not need many services outside of physical needs. They want to be with normals.

Dr. Sehler mentioned a statement she helped to formulate with Robert Mayberry and M. Elliot along with the local chapter of the United Cerebral Palsy Association of Michigan. They would not have succeeded in formulating this statement or questionnaire if they did not let the local Lansing group of physically handicapped get involved.

National Farm Home Project - She suggested that I contact Phillip Thomas, President of the Lansing Association of the Physically Handicapped. This questionnaire was intended for physically handicapped who were interested in low cost housing. Copies of this questionnaire were sent to the United Cerebral Palsy Association and to vocational rehabilitation people. The NAPH took the leadership in this project. The individual who received this questionnaire filled it out and mailed it to the president of the NAPH. Duplicate copies were sent to Mrs. Sehler. A statewide representative committee of this agency was formed. The NAPH (parent group) took the leadership. The Lansing Coordinating Committee For the Handicapped was the sponsoring Agency. Mrs. Sehler provided me with copies of the questionnaire and application form. She also contacted Helen Parsons, a former teacher who acts as a social worker in this project. Mrs. Parsons tracked down each applicant and provided transportation to the housing office (NaPH) in order to have the real forms filled out. She tracks down those who indicate they are interested in housing within six months. M. Elliot allocated ten units. Many handicapped people have families and really belong in other units. Another group being cared for needs some form of subsidized housing. Some handicapped need to be able to buy low cost housing (FHA). People have been referred to the FHA and the help of the United Cerebral Palsy Association, they live in a couple situation and are provided services through the University of Michigan, Dept.

of Vocational Rehabilitation. Thus, Dr. Sehler feels that Vocational Rehabilitation Agencies have to be incorporated as supporting agencies for the physically handicapped. They have had a difficult time filling these units for the following reasons: (1) people are afraid to make a new move (2) there hopes have been built up before and have only been let down.

The present federal laws for housing are for the aged rather than the handicapped. The Administration doesn't want to work with the handicapped. She mentioned New Horizons, Report on Realistic Hospital Living by Adult Handicapped, New Britain Connecticut, 1961.

Dr. Sehler emphasized that once a unit is seen it helps reinforce the handicapped. Goodwill Industries of Toledo Ohio set up housing units for adult handicapped. M. Elliot visited them and was not impressed. However, it was a beginning.

Some of the needs of the aged physically handicapped is the accesibility of stores, parking facilities. Some might want to walk to these areas. The blind need specially marked elevators. Otherwise they usually adapt to normal housing.

Dr. Sehler took me to a newly built housing unit for adult handicapped on 3200 W. Washington, Lansing, Michigan. It was designed for the aged and multiple types of handicaps. This building had to meet certain federal requirements. The apartment building had 188 units and was built at a cost of $2,700,000. This unit is located on 4 1/2 acres of property.

We visited one of the inhabitants, a severely involved paraplegic cerebral palsied woman. Her apartment had an efficiency kitchen, living room, bedroom and bathroom. Except for the fact that the cupboards were too high in the kitchen, she was very satisfied. The supervisor explained that the kitchen had to be built to certain specifications since the building was originally constructed for the elders. The inhabitant of the apartment said that the most important thing to her in any apartment is the bathroom. She needs easy accessibility. The doors have to be wide enough for her wheelchair to get through and the sinks and toilet stools need to be low enough to be reached. She wassatisfied with her bathroom.

This 188 unit building is located less than a block away from a shopping center, and is very close to an auto service garage. The closets have folding doors. Each apartment has an emergency buzzer with a string attached and thus help can be always reached. This building has a recreation room for Senior citizens and outside agencies and community organizations are invited to the functions.

Interview of Margaret Schilling, United Cerebral Palsy Association of Detroit, 10 Peterburo, Suite 200, Detroit, Michigan, by Milton Hyman, August 10, 1970.

This association runs a three level project in Farmington, Michigan.

Level I: Living Opportunity Program

A 30 bed unit for severely involved. It serves various types of handicaps. Many need to be moved to a more sheltered situation.

Level 2

This consists of married cerebral palsied individuals. Some are more able to work than others. There are 20 couples who are in need of low cost housing.

Level 3

The parents of these cerebral palsied individuals are still alive, and are fairly affluent and independent. Their children should begin to live alone. They are partially ambulatory, and have average, and dull I.Q.'s. Some have attended Orthepedic's schools. This group aged 17-25 could benefit from apartment living with someone else (perhaps M.R.). They can draw medical and social security. Some are drawing aid to the disabled. If they left home they could get up to $130. per month social security. The total cost for the living opportunity program is $14.88 per day for the severely involved.

Transportation is very critical. These patients are afraid to live in the inner city. The patient population is mostly white, middle or lower middle income. A number are still in Lapeer or Coldwater. They should not be there and have acquired institutional handicaps. They require halfway house supervision.

Needs of Adult Cerebral Palsied

Needs lots of programming. They are not adept at using appliances. Have severe dental problems. Transportation is also a problem. They also have visual problems. They have orthepedic needs such as braces but these are usually taken care of. Residences for cerebral palsied should have flat surfaces without stairs. Kitchen should be designed for the handicap. There should be a warning or alert system. They get along on smooth surfaces better than on carpeting (less friction). Most of the furniture should be attached or built in. Dining room tables should be adjustable to height. Stoves should have back burners in order that the cerebral palsied would not reach over flame.

Interview of Dr. William Sloan, 401 South Spring Street, Springfield, Illinois of the Division of Mental Retardation, by Milton Hyman, August 14, 1970.

There are seven new institutions in Chicago for the severe and profound retarded who are divided into 250 mobiles and 150 non-mobiles for 400 beds. Dr. Sloan mentioned the following sources by Julius Cohn, Manpower and Mental Retardation and National Institute of Child Health.

Dr. Sloan feels that community based services are needed to replace the institutions for many mentally retarded. One needs such things as regional planning, prenatal care, early detection, and a recreational program. The type of housing structure or unit must vary with the individuals' mental level, age, physical condition.

In the State of Illinois the care for the mentally retarded is divided into 8 zones or regions. Dr. Sloan has provided me with literature explaining this concept in detail. Each zone has different needs for the mentally retarded. For example, Chicago is broken down into severe and mild retarded. In this zone, like the others, the State of Illinois knows who is retarded, who can work, age, degree of retardation, etc. Programs are built around these factors. Another example is Zone 6. It has a population of 816,000 and has 11,749 retarded individuals.

Each zone is divided into planning areas. Dr. Sloan feels that in a well rounded program, housing is only one facet. For example, if a 100 trainable individuals were provided with:

(1) Special Education classrooms
(2) Day care centers
(3) pre-vocational planning
(4) Homemaker services
(5) Social facilities

This would cost less than to build a 100 bed unit. Thus, housing has to be a part of the total perspective.

In Illinois the degree to which services are offered to the mentally retarded were studied (dental and medical needs). An example of a Zone summary in Illinois is one which includes:

(1) population
(2) mildly, severely retarded
(3) how many residential beds are available
(4) specialized programs
(5) geography etc.

These detailed summaries are presented to the Illinois governmental bureaus of budgets and programs are designed in respect to present and future needs.

Estimates on incidence of mental retardation:

There is one MR bed per 100 population for residential care. The U. S. average is about 92 per 100,000. In 1968, admissions for MR were 7 1/2 per 100,000 population.

Dr. Sloan feels that MR programs in Michigan should be developed in respect to differences found in Michigan with respect to other states and similarities. Rhode Island for example, has different residential needs than Idaho. Any attempt for housing MR should include specific definitions of the different types of MR. He believes that mildly retarded who are working, do not need many specialized services or unique housing needs.

Dr. Sloan suggested that I contact Mr. Harvey Zukorberg, 510 Michigan Avenue, National Building, Lansing, Michigan. Dr. Sloan provided me with a great deal of literature and he suggested that we give him some sort of consultant fee for the three hours he spent with me during the interview. He did not say what amount he wanted but he gave me his social security number, 361 01 8831.

Another bibliographical reference cited was Long Term Needs for Severely Retarded and Multiple Handicapped. US Government Printing Office, 1967.

Dr. Sloan mentioned a Housing Structure for retarded located in Aurora Illinois which has about 500 rooms. An organization called Unit-Care bought the Hilton Inn in Aurora for about $4,000,000 and are now using this structure for about 450 mild and moderately retarded adults. Aurora is about 40 miles from Chicago.

He suggested another agency that I would contact. Program Director Accreditation Council for Facilities for the Mentally Retarded 645 N. Michigan Avenue, Chicago Illinois, 60611.

Interview of Robert Mayberry and Roy J. Morrison, Executive Director of the United Cerebral Palsy Association of Michigan, 202 East Boulevard Drive, Flint, Michigan, July 17, 1970.

Mr. Mayberry felt that a comprehensive statement of why there should be low cost housing for adult handicapped should be clearly stated. He stated that our definitions of adult handicapped eligible for low income housing should include those who are reasonably socially competent, could live outside an institution after parents have died, and who need a place to live.

Mr. Mayberry and Mr. Morrison mentioned the Lansing Project for low income housing for the handicapped, headed by Arselia Sehler, Box 420-Michigan Department of Education, Lansing, Michigan. They suggested that I should contact the various state chapters of the associations for the handicapped.

Their impression of the Lansing project was that there was difficulty filling the available space with handicapped individuals. They felt the problem centered about the fear of handicapped people toleave the protective environment of their homes. It was advised that any low income housing project for adult handicapped should include counseling and experiences in how to live away from your home. They felt that such counseling should begin before the handicapped individual reaches adulthood. This could be done with field-trips or week-end camping excursions. They gave an example of a thirty-five year old handicapped Flint man who was very capable to live away from home but was afraid to cut his family ties. His fear caused him to cancel a field trip to Detroit.

They gave me literature concerning the California study. This study outlines how handicapped people can be helped by supporting services to live in their own homes.

Mr. Mayberry and Mr. Morrison felt that we could have difficulty in finding qualified individuals to fill low cost housing units. They mentioned that Margaret Shilling of the Detroit Cerebral Palsy Center, conducted a Detroit survey to find handicapped individuals who might qualify for low income housing. She came up with only one solid person.

Mr. Mayberry said that he hoped he did not appear too pessimistic about the numbers of adult handicapped individuals who might use low cost housing. He said that attitudes could change in the next five years. He claimed that there were similar problems when low cost housing for the aged was first attempted.

Both Mr. Mayberry and Mr. Morrison felt that adequate transportation facilities would have to be a crucial consideration for any project concerning low cost housing for adult handicapped who are working. For example, some handicapped people could find work if they had adequate transportation.

Mr. Mayberry stated that he would like to see any housing facility for adult handicapped to be integrated into units with non-handicapped individuals.

Interview of Mrs. Wagner and Mr. Benike of Wagner House, New Horizons, Farmington, Michigan by Milton Hyman.

Mr. Benike and Mrs. Wagner are involved in a new housing situation for the mentally retarded, New Horizons which will be located in Farmington, Michigan. Mrs. Wagner is a teacher of the mentally retarded in Farming High School, and Mr. Benike is an architect. Both are trustees of Community Living Center Inc. Mrs. Wagner, also runs two homes for mentally retarded at 30301 13 Mile Road (Wayne House). These are two homes located near Farmington, Michigan. The larger home has seven boys and 3 girls. The smaller house has 7 boys. The surroundings have a very pleasant country atmosphere. The residents appear to be quite happy. Mrs. Wagner has provided me with literature which describes the program at Wagner House.

Mr. Benike is concerned with designing the shelter for the various units. He feels that proper zoning can be achieved by the proper salesmanship and presentation to the various communities. He claims he has two communities (which he did not give the names) who are now willing to listen for possible zoning. He believes that one should reveal exactly what is to be done to the various communities. He stated that New Horizons would have locations in Farmington and Madison Heights, Michigan.

At Wagner House the goal is to bring about as normal a social, recreational, and residential situation as possible. For example, one boy residing at Wagner House spent 13 years at Lapeer, and is now working as a janitor. Another boy spent 17 years at Lapeer and is satisfactorally employed in a nursing school.

Mr. Benike is associated with Benike and Krue Co., Architects and Builders. Both Mrs. Wagner and Mr. Benike believe that residences for the mentally retarded should be planned with the following in mind:

(1) They need shelter from some of the harmful influences (some urban influences such as skid row etc.).
(2) Yet, they should not be relocated too far away from their families.
(3) Residential facilities should be small rather than large apartments like or institutional like settings.
(4) Many of these smaller facilities should be constructed in different areas.to facilitate the integration of these mentally retarded adults into the various communities. He feels that at least as far as Oakland County is concerned, extremely large residential units in individual communities would make integration difficult. For Oakland County, they favor smaller facilities. These residences should resemble or in actuality be normal type residences.

They refereed to a YMCA program in Oakland County called Guys and Dolls developed for the mentally retarded. There are now 48 retarded in this program. It is written up in the YMCA magazine and is an example of how a community agency can help get mentally retarded integrated into community affairs. They feel that there should be one central residence which could serve as an evaluation facility for residential programs for the mentally retarded.

Their Board of Directors are a diversified group of talents and vocations. The following names were listed as Board of Directors, New Horizons:

1. Jerry Harrison: Former Superintendent for 20 years, now retired but involved in housing for the mentally retarded.
2. Lloyd Smith, CPA, Treasurer.

3. Bernard Trumpetor, President, Oakland County Association of Retarded Children.
4. Rita Charren, Community Representative, Lapeer State Home.
5. Gary Carly, Lawyer, President of New Horizons.
6. Mrs. Thomas Goat, Secretary.
7. Mrs. Cotton, Teacher and Counselor in Farmington.
8. Edward Bassett, Parent of one of the residents of Wagner House.

New Horizons hopes to provide a complete life, social, work, recreation - almost a country club atmosphere for the mentally retarded.

III

LEGISLATION PERTAINING TO ARCHITECTURAL BARRIERS

Act No. 1
Public Acts of 1966
Approved by Governor
February 11, 1966

Enrolled House Bill No. 2016

An act to provide for the accessibility and the utilization by the physically handicapped of certain public buildings constructed with funds of the state or its political subdivisions and to provide for the enforcement of the act.

The people of the State of Michigan enact:

Sec. 1. As used in this act:

(a) "Physical handicap" means an impairment which confines an individual to walk with difficulty or insecurity; affects the sight or hearing to the extent that an individual functioning in public areas is insecure or exposed to danger; causes faulty coordination or reduces mobility, flexibility, coordination and perceptiveness to the extent that special facilities are needed to provide for the safety of that individual.

(b) "Administrative authority" means the state official responsible for the administration and enforcement of the provisions of the act.

(c) "Building" means a structure to which the public customarily has access and utilizes and which is constructed, in whole or in part, with funds of the state or its political subdivisions.

Sec. 2. (a) Buildings constructed in this state after the effective date of this act shall meet the requirements for the provision of access and utilization by the physically handicapped as are promulgated by the state building division except where the administrative authority determines, after considering all circumstances applying to the building, that full compliance is impracticable.

(b) Existing buildings undergoing major remodeling or rehabilitation after the effective date of this act shall meet the requirements of this act except where the administrative authority determines that full compliance is impracticable.

(c) Approval of the administrative authority shall be secured before the awarding of construction contracts for any building covered by this act.

Sec. 3. (a) The administration and enforcement of this act in respect to all public buildings, except for school buildings other than at institutions of higher education as defined in section 4, Article VIII of the state constitution, which are included in section

3a of this act, are vested in the department of education.

Sec. 4. The state building division is empowered to adopt and promulgate such reasonable and standard rules and regulations for the effective administration of this act, as it shall deem necessary, after consultation with the department of education, which are not inconsistent with the provisions of this act or any law of this state. The rules authorized hereunder shall be in accordance with established practicable means for securing safety and shall be based upon generally accepted nationwide engineering standards and practices. The rules and regulations promulgated by the state building division shall be in accordance with the provisions of Act No. 88 of the Public Acts of 1943, as amended, being sections 24.71 to 24.82 of the Compiled Laws of 1948, and subject to Act No. 197 of the Public Acts of 1952, as amended, being sections 24.101 to 24.110 of the Compiled Laws of 1948.

The rules and regulations will be administered and enforced by both administrative authorities in their respective areas.

Sec. 5. Any person responsible for the awarding of construction contracts which are in violation of the provisions of this act is guilty of a misdemeanor.

Sec. 6. This act shall become effective on July 1, 1966.

This act is ordered to take immediate effect.

Rules for Administration and Enforcement
Effective ...August 15, 1967

R 1.501. Scope and Purpose.

Rule 1 (1) The terms defined in Act No. 1 of the Public Acts of 1966, being sections 125.1351 to 125.1356 of the Compiled Laws of 1948, which Act is implemented by these rules, are applicable to these rules.

(2) These rules govern the design and construction of public buildings, new or with major remodeling or additions thereto and the con tracts which are awarded after the effective date of these rules.

(3) These rules are intended to make such buildings accessible to and functional for any physically handicapped person employed, visiting, or on the building premises for any reason.

R 10.502. Definitions.

Rule 2 As used in these rules:

(a) Appropriate number means the number of a specific item necessary to serve the needs of the anticipated number of physically handicapped persons who will use the building.

(b) Building Division means the Building Division of the Bureau of the Budget of the Executive Office.

(c) Contracting Officer means the responsible administrative

officer representing the unit of government that contracts for the construction of a building.

(d) Walk means a smooth, hard prepared surface of concrete, bituminous concrete, brick, stabilized gravel, or other material with the ground immediately adjacent thereto at the same level.

(e) Ramp means a smooth, hard prepared, sloped surface joining two different levels.

R 10.503. Parking Lots, Building Approaches and Entrances.

Rule 3 (1) The parking lot servicing the entrance described in Rule 3 (2) shall have an appropriate number of parking spaces adjacent to a walkway and identified as reserved for physically handicapped persons. Each reserved parking space shall be surfaced suitably for wheelchair travel and shall be at least 12 feet wide, unless paralleling a walk. Where a curb exists between a parking lot surface and a sidewalk surface, an inclined walk or a curb cut with a maximum gradient of 1 foot in 3 feet (33 1/3%) shall be provided for wheelchair access.

(2) At least one primary entrance to the building conforming with the requirements of Rule 4 (3) shall be accessible from the parking lot or the nearest street by way of a walk uninterrupted by steps or abrupt changes in level and having a minimum width of 5 feet and a maximum gradient of 1 foot in 20 feet (5%) or a ramp meeting the requirements of Rule 4(2).

R 10.504. Stairs, Ramps, Doors and Multilevel Floors.

Rule 4 (1) Stairs shall have risers not exceeding 7 1/2 inches and nosings with a minimum radius of 1/8 inch. Stairs shall have handrails 32 inches above stair nosing on both sides with the handrail extended 18 inches beyond the top and bottom step on the wall side of main stair landings. Intermediate stair landings shall have continuous handrails on both sides. Stairs and landings shall have surfaces that are not slippery.

(2) An outside or inside ramp shall have a maximum gradient of 1 foot in 12 feet (8 1/3%) with a level platform 5 feet long at the top and bottom and at turns and at a maximum interval of 30 feet on long runs; and shall have a minimum clear width (inside handrails) of 32 inches. Outside and inside ramps, including platforms, shall have handrails 32 inches high on both sides with the handrail extended 12 inches beyond the top and bottom of the ramp on at least one side. All ramps, including platforms, shall have surfaces that are not slippery.

(3) A door shall have a clear opening of at least 32 inches when open. In the case of double doors without a mullion, one of the pair shall meet this requirement. The floor shall be level for a distance of 5 feet from the door in the direction of the door swing and shall extend 1 foot to the side of the latch jamb of the door. A threshold shall have a minimum rise and shall have an incline to facilitate wheelchair travel.

(4) All areas on the same floor shall be of a common level or connected by a ramp meeting the requirements of Rule 4 (2).

R 10.505.Sanitary Facilities.

Rule 5 (1) An appropriate number of toilet rooms and units within such room shall be accessible to, and usable by, physically handicapped persons. A toilet room shall have a clear space of at least 5 feet square to permit turning a wheelchair around. Minimum clear width in the room shall be 4 feet. A toilet stall shall be at least 3 feet wide and 4 feet 8 inches deep, have an out-swinging door (or an opening) 32 inches wide and handrails 33 inches (lower for children) above and parallel to the floor on each side. A water closet shall have a narrow understructure that recedes sharply from the front (the trap shall not extend in front of, or be flush with, the lip of the bowl). A lavatory shall be wall mounted and have a narrow apron with the bowl near the front to permit use by an individual in a wheelchair. A shelf, towel dispenser, disposal unit and the lower edge of a mirror shall not be more than 40 inches above the floor. A wall mounted urinal shall have a basin opening not more than 19 inches above the floor.

(2) An appropriate number of drinking fountains or other water dispensing means shall be accessible to, and usable by, physically handicapped persons. A wall mounted drinking fountain or cooler shall have a spout and control at the front of the unit with the basin located not more than 36 inches above the floor and shall not be fully recessed. A floor model water cooler shall have a side mounted fountain 30 inches above the floor that is accessible to an individual in a wheelchair.

R 10.506. Telephones, Elevators and Switches.

Rule 6 (1) An appropriate number of telephones shall be accessible to, and usable by, physically handicapped persons. Such telephones shall be located outside a conventional booth with the dial and handset not more than 48 inches above the floor. An appropriate number of telephones shall be equipped for persons with hearing disabilities and so identified with instructions for use.

(2) Elevators shall be provided in multi-story buildings to serve the floor containing the entrance meeting the requirements of Rule 3 (2) and all other floors accessible to the public. The elevator cab shall have a minimum clear area of 25 square feet and a door with a minimum clear opening of 32 inches. Metal braille plates shall be provided for floor selection and other controls (open door, stop car, emergency signal, etc.) adjacent to standard floor and control buttons within the cab. The maximum height of floor and control buttons shall be 60 inches above the floor with banked button arrangement where necessary. Metal braille plates shall be provided for floor designation on each floor, 5 feet above the floor, on the fixed jamb at the open side of the elevator door.

(3) Light switches shall be located not more than 48 inches above the floor.

R 10.507. Corridors and Room Identification.

Rule 7 (1) Light fixtures, protruding signs, door closers and similar hanging objects or signs and fixtures shall not be lower than

6 feet 8 inches above the floor.

(2) Corridors shall have a minimum width of 4 feet and the end of a corridor shall have a minimum area of 5 feet square to permit turning a wheelchair around.

(3) Room identification plates (metal, plastic or other suitable material) with minimum 1 1/4 inch high raised letters or numbers, similar to a so called "super sign", shall be affixed to the wall surface approximately 5 feet above the floor, in a horizontal line, adjacent to the latch side of a door. Doors leading to dangerous areas such as fire escapes, loading platforms, switch rooms and mechanical rooms shall be equipped with knobs, handles or push bars that have been knurled.

R 10.508. Special Rooms.

Rule 8 (1) Rooms having sloping floors or fixed seats or both, such as auditorium and lecture rooms, shall have accomodations for wheelchair individuals. These areas shall be accessible from a common level floor or by a ramp meeting the requirements of Rule 4 (2).

R 10.509. Administration and Enforcement.

Rule 9 (1) The Department of Education will administer and enforce these rules for those instructional and supporting service buildings, through the twelfth grade level that are administered by public school and intermediate school districts. The Building Division will administer and enforce these rules for all other buildings.

(2) An apparent conflict between the application of these rules to a building and other state laws pertaining to the design of public buildings shall be reported to the Building Division or the Department of Education for resolution.

(3) The contracting officer shall forward, or have forwarded by the architect or engineer, one set of completed plans and specification (including those for the site development) to the proper administering agency for review. Two weeks shall be allowed for their review. If all areas of the building and its approaches are not in conformance with these rules, the plans and specifications shall be accompanied by a statement signed by the contracting officer describing the conditions or situations that warrant the exceptions and requesting that the exceptions be approved. The exceptions will be approved only when it is clearly evident that equivalent facilities and protection are provided.

(4) A notice of approval of the plans and specifications as submitted or a letter requesting changes therein will be sent to the contracting officer. Prior to the award of construction contracts the notice of approval shall be secured by the contracting officer.

(5) A change in plans or specifications affecting any part of the building covered bythese rules subsequent to approval by the administering agency shall be resubmitted for approval prior to construction.

Public Law 90-480
90th Congress, S. 222
August 12, 1968

AN ACT

To insure that certain buildings financed with Federal funds are so designed and constructed as to be accessible to the physically handicapped.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That, as used in this Act, the term "building" means any building or facility (other than (A) a privately owned residential structure and (b) any building or facility on a military installation designed and constructed primarily for the use by able bodied military personnel) the intended use for which either will require that such building or facility be accessible to the public, or may result in the employment or residence therein of physically handicapped persons, which building or facility is---

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(1) to be constructed or altered by or on behalf of the United States;

(2) to be leased in whole or in part by the United States after the date of enactment of this Act after construction or alteration in accordance with plans and specifications of the United States; or

(3) to be financed in whole or in part by a grant or a loan made by the United States after the date of enactment of this Act if such building or facility is subject to standards for design, construction, or alteration issued under authority of the law authorizing such grant or loan.

SEC. 2. The administrator of General Services, in consultation with the Secretary of Health, Education, and Welfare, is authorized to prescribe such standards for the design, construction, and alteration of buildings (other than residential structures subject to this Act and buildings, structures, and facilities of the Department of Defense subject to this Act) as may be necessary to insure that physically handicapped persons will have ready access to, and use of, such buildings.

SEC. 3. The Secretary of Housing and Urban Development, in consultation with the Secretary of Health, Education, and Welfare, is authorized to prescribe such standards for the design, construction, and alteration of buildings which are residential structures subject to this Act as may be necessary to insure that physically handicapped persons will have ready access to, and use of, such buildings.

Sec. 4. The Secretary of Defense, in consultation with the Secretary of Health, Education, and Welfare, is authorized to prescribe such standards for the design, construction, and alteration of buildings, structures, and facilities of the Department of Defense subject to this Act as may be necessary to insure that physically handicapped persons will have access to, and use of such buildings.

Applicability.

Sec. 5. Every building designed, constructed, or altered after the effective date of a standard issued under this Act which is applicable to such building, shall be designed, constructed, or altered in accordance with such standard.

Sec. 6. The Administrator of General Services, with respect to standards issued under section 2 of this Act, and the Secretary of Housing and Urban Development, with respect to standards issued under section 3 of this ACT, and the Secretary of Defense with respect to standards issued under section 4 of this Act, is authorized---

Waiver

(1) to modify or waive any such standard, on a case-by-case basis, upon application made by the head of the department, agency, or instrumentality of the United States concerned, and upon a determination by the Administrator or Secretary, as the case may be, that such modification or waiver is clearly necessary, and

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Surveys and Investigations

(2) to conduct such surveys and investigations as he deems necessary to insure compliance with such standards.

Approved August 12, 1968

TITLE 24--HOUSING AND HOUSING CREDIT

SUBTITLE A--OFFICE OF THE SECRETARY,

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

PART 40--STANDARDS FOR DESIGN, CONSTRUCTION, AND

ALTERATION OF PUBLICLY OWNED RESIDENTIAL STRUCTURES

Part 40 of Title 24 is established to read as follows:

Sec.

AUTHORITY: The provisions of this Part 40 issued under sec. 3, Public Law 90-480 (42 U.S.C. 4153); sec. 7(d), Department of HUD Act (42 U.S.C. 3535 (d)).

40.1 Purpose.

This part prescribes standards for the design, construction, and alteration of publicly owned residential structures to insure that physically handicapped persons will have ready access to, and use of, such structures.

40.2 Definition of "residential structure."

(a) As used in this part, the term "residential structure" means a residential structure (other than a privately owned residential structure and a residential structure on a military

reservation):

(1) Constructed or altered by or on behalf of the United States;

(2) Leased in whole or in part by the United States after August 12, 1968, if constructed or altered in accordance with plans and specifications of the United States; or

(3) Financed in whole or in part by a grant or loan made by the United States after August 12, 1968, if such residential structure is subject to standards for design, construction, or alteration issued under authority of the law authorizing such grant or loan.

(b) As used in this part, "residential structure" includes the following:

(1) Any residential structure which, in whole or in part, is intended for occupancy by the physically handicapped or designed for occupancy by the elderly;

(2) All elevator residential structures;

(3) Any residential structure which contains 25 or more housing units; and

(4) Nonresidential structures appurtenant to a residential structure covered under this part.

40.3 Applicability.

(a) The standards prescribed in 40.4 are applicable to residential structures designed after the effective date of this part. If the design of a structure commenced prior to that date, the standards shall be made applicable to the maximum extent practicable, as determined by the head of the department, agency, or instrumentality of the United States concerned. If no design

stage is involved in the construction or alteration of a residential structure, the standards of 40.4 shall be applicable to construction or alteration for which bids are solicited after the effective date of this part.

(b) The standards prescribed in 40.4 are not applicable to:

(1) Any portion of a residential structure or its grounds which need not, because of its intended use, be made accessible to, or usable by, the public or by physically handicapped persons;

(2) The alteration of an existing residential structure to the extent that the alteration does not involve work which is related to the standards of this part; or

(3) The alteration of an existing building, or of such portions thereof, to which application of the standards is not structurally feasible.

40.4 Standards.

(a) Residential structures subject to this part shall be designed, constructed, or altered to insure that physically handicapped persons will have ready access to, and use of, such structures. This requirement shall be satisfied by using the specific ations contained in the "American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped, Number A117.1-1961," approved by the American Standards Association, Inc. (subsequently changed to United States of America Standards Institute), herein referred to as the "American Standard Specifications." Except as otherwise provided in paragraph (b) of this section, the standards shall be

applicable to the extent provided in the American Standard Specifications.

(b) Application of the American Standard Specifications is modified as follows:

(1) The specifications in section 5.6 are applicable to toilet rooms which are provided for the public. Although no specifications are prescribed in section 5.6 for bathrooms in individual housing units, consideration shall be given to the need for access by the physically handicapped in connection with the design, construction, or alteration of such bathrooms.

(2) The specifications in section 5.10, "Controls," and 5.11, "Identification," are recommended specifications but not mandatory.

40.5 Waiver.

The applicability of the standards set forth in this part may be modified or waiver on a case-by-case basis, upon application to the Secretary of HUD made by the head of the department, agency, or instrumentality of the United States concerned, only if the Secretary determines that such waiver or modification is clearly necessary and consistent with the purpose of Public Law 90-480 (42 U.S.C. 4153).

40.6 Records.

The administering agency's file on each contract, grant, or loan involving the design, construction, or alteration of a residential structure shall include appropriate documentation indicating: (a) that the standards prescribed in 40.4 are applicable to and have been or will be incorporated in the residential structure, or (b)

that the grant or loan has been or will be made subject to the requirement that the standards are applicable and will be incorporated in the residential structure. The file should also indicate any modification or waiver of the standards which has been issued by the secretary of HUD.

Effective date. This part shall be effective October 24, 1969.

George Romney
Secretary of Housing and Urban Development

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ADDENDA

ADDENDA TO THE PRELIMINARY REPORT
OF DEMONSTRATION COMMUNITY HOUSING PROGRAMS
FOR THE MENTALLY RETARDED,
PHYSICALLY HANDICAPPED AND MENTALLY ILL

TABLE OF CONTENTS

ADDENDA TO THE PRELIMINARY REPORT
OF DEMONSTRATION COMMUNITY HOUSING PROGRAMS
FOR THE MENTALLY RETARDED,
PHYSICALLY HANDICAPPED AND MENTALLY ILL

(as per request of memorandum from
James A. Roberts to William G.
Rosenberg dated October 28, 1970)

I Definition and Documentation of Need:

Accurate information on income levels and employment status on the types of retarded individuals who might be prospects for housing contemplated in this study is almost unavailable. The most comprehensive study of social adequacy and of social failure of the retarded was done at Wayne State University in 1959*. This study indicated that the mean average income per week was $50.00-54.00 for the group studied. The comparable black groups earnings were appreciably less than this figure. If these figures are treated with the average national increase in income over the past 10 years the range would be approximately $75.00-80.00 per week. One must exercise caution, however, in the interpretation of these figures for the adult independent retarded as their upward mobility in jobs is fixed, they are restricted to lower paying, less sophisticated jobs, and they are the first to feel the impact of employment cutbacks.

*Social Adequacy and Social Failure of Mentally Retarded Youth in Wayne County, Michigan, Wayne State University, 1959.

The unattractiveness, employment-wise, of the retarded would indicate that facilities for them should be located in areas offering many and diversified job opportunities. This would indicate locations near large metropolitan and industrialized settings.

Additionally, although the original report addresses itself to the physically handicapped and emotionally ill as well as the mentally retarded it is suggested that the initial housing resource be constructed for the mentally retarded and that, hopefully, comparable facilities for the other handicaps would follow. When one evaluates the dynamics of handicaps, it would seem that the better choice would be to construct a facility for no more than 30 retarded in or very near a housing situation for normal individuals of comparable age.

A. Identification of existing non-institutional residential facilities which may be comparable or have relevance to the program being proposed for Michigan:

The concept of non-institutionalized community residential facilities for mild and borderline mentally retarded is relatively new and there are not many examples of such programs in existence. However, there are a number of facilities located in Illinois, Wisconsin, New York, California and Washington which appear to have programs relevant to the needs of a community residential facility for Michigan. There are, also, some facilities in England, Denmark and Sweden which may have some relevance

to Michigan's proposed program and are therefore worth describing:

Illinois

Aurora Center: 230 South Lincoln Way, North Aurora, Illinois 60542. Elvin Koester, Administrator.

Clients

This facility which opened on August 1, 1970 has 185 residents, 18 years of age and older (average age 35). The majority of the clients fall in the mild or moderate retardate range. Since the State of Illinois does not have licensing standards for a residential facility such as the Aurora Center, it has been licensed for 500 mentally retarded under sheltered care standards. The Illinois Department of Mental Health and Public Aid are currently working on licensing standards for this new category of care. The Aurora Center serves those individuals who are deemed capable of functioning in a community based residential care and training facility and can progress towards a greater degree of independent living, achieving at least partial self-support under supervision in a minimal control environment.

Physical Plant, Design and Architecture (13 acre site)

This facility contains 7 distinct living units with approximately 35 to 44 rooms in each unit comprising a total of 278 rooms. Room size varies from approximately 210 to 480 square feet; accomodating two to three residents, offering

space for television, work desk and appropriate storage space. Each room has a complete private bath. Each desk has a built-in 5 channel radio. This facility has its own heating and air-conditioning unit.

Sources:

Interview, 11/18/70 with Elvin Koester, and Patrick L. Saunders, ACSW Programmer, Unicare Health Services Inc.

Saunders, P. L. Performa Aurora Center, pres ed to Dr. William Sloan, Director, Division of Ment.. Retardation, Illinois Department of Mental Health, 1970.

Elizabeth Ludman Mental Retardation Center

Park Forest, Illinois - A. Epstein and Son's Inc.

Clients

400 severely and profoundly retarded. Although designed for children ages 6-16, it is representative of Illinois' concept in residential care for retarded and could give some financial, architectural and supporting agency guidelines.

Physical Plant, Design and Architecture.

It is located on a 60 acre site and has 50 four-bedroom, one-story brick, ranch type homes. The center mall contains the facilities' auxilliary services: administrative offices, professional services, a library, chapel, clinical services, physical training center, swimming pool, exercise and multi-purpose room, social training center, 200 seat auditorium, shopping and snack bar facilities. Eight people live in each four bedroom home. Each unit has its own kitchen, heating and air-conditioning unit.

Source:

Elizabeth Ludman Mental Retardation Center. Park Forest, Illinois: A. Epstein and Sons, Inc. 1969.

Wisconsin:

Council House - 2003-2007 West Kilbourn Avenue, Milwaukee, Wisconsin. A residential care program for mild and borderline mentally retarded sponsored by the Milwaukee Council of Jewish Women (a branch of the Milwaukee Jewish Vocational Services).

Clients

There are 7 young male adults and 7 young female adults in Phases I and II of the program.

Purpose

The purpose of Council House is to provide work oriented mental retardates with training services aimed to prepare them for independent living and to provide supervised small group living for persons whose own family can no longer provide a home; who are ready for transfer from institutional residence; whose home community offers limited or no opportunities for vocational rehabilitation; and who need a short term residential facility.

Residential Facility

This is an old, renovated two-story, two-family home with spacious living rooms, large bedrooms, dens, and closet space. The bathrooms, kitchens, dining areas, can accomodate about 20 people.

Sources:

Interview, 8/7/70, with Mrs. Patricia Malnekoff, Jewish Vocational Service, Milwaukee, Wisconsin.

The Work Adjustment Training Program: Jewish Vocational Service: Milwaukee, Wisconsin.

New York

Fineson House Center, Association of Health for Retarded Children's Adult Residence, Director, A. Payne. 208 E. 17th Street, Manhattan, New York.

Clients

Fineson House is the first hostel or halfway house to be opened in New York City as part of a pilot project of hostels to be set up with state aid. This facility has 6 adult females, and 6 adult male residents (average age 35-38). One resident is seventeen. The residents are required to be working competitively 40 hours per week at the minimum wage scale of $1.90 an hour; or employed in a sheltered workshop facility in which they are paid on the basis of their productivity.

Physical Plant, Design, Architecture

This facility is a double brownstone located on two lots and is four stories high. It has 26 rooms including a common dining room and can house between 25 and 30 residents. The basement and first floor houses the living facilities, kitchen and offices. The second, third and fourth floors house the bedrooms.

Sources:

Fineson House Center: Association of Health for Retarded Children's Adult Residence. Director, Aubrey Payne. Interview (telephone) with Sherry Calavas, Secretary, 11/24/70.

"First hostel opens in New York City." Mental Retardation News, September, 1970, p. 7.

The Educational Guidance Center for the Mentally Retarded

1160 5th Avenue, New York 10029. Herbert Goldstein, Director.

This proposed facility which is still in the planning stage will have the ground breaking in December of 1970. The "Residence" as it will be called, is a privately sponsored tax exempt corporation registered with the Charities Registration Bureau, of the Department of Social Welfare, State of New York. This facility proposes to be the first residential research center of its kind in the United States, its purpose is "dedicated to studying that vast group of near-normal retardates (adult) someday capable of success with minimal help, in both competitive industry and private life."

Client Requirements

This apartment type facility will house a group of 130 educable retarded men and women who must be employed in competitive employment and be at least 18 years of age. They can also be in training for competitive employment.

Physical Plant, Design and Architecture

The facility will be a five-story (200 apartments) designed

for singles and married couples.

Source:

The Educational Guidance Center for the Mentally Retarded. If ever a plan was right for the bright retarded. New York: 1970.

California

Generally, California is still in the planning stage in the development of community residential programs for the mentally retarded. However, there are several facilities, hypothetical and operating for retarded adults and one facility for children whose programs may have some relevance to Michigan's needs.

Hypothetical Apartments for Marin County California

Proposed by Marin Aid to Retarded Children for mentally retarded adults.

Clients

The purpose of this program is to supply needed housing near public transit and to make counseling easily available for semi-independent retarded adults who are presently residing in a state institution. These clients who have been prepared for productive participation in the community, who are independently employed or sheltered workshop employed and who, with a minimum of supportive services can operate in the community and largely support themselves.

Proposed Design and Architecture of Physical Plant

This facility would house between fifty and sixty residents. It would be a two-story structure, divided into two sections

and separated by a commons. The commons would have large open areas on the ground floor with a cafeteria, recreation room, laundry facilities. It would be a type of open plan with partial walls and glass dividers. There would be office space for resident staff, participating agencies, and controlling agencies.

Miriam Comito - Fairfax, California

This privately owned facility has six adult educable and borderline retarded males (ages 19 to 23). The purpose of this residential program is to provide sheltered living for young retarded adults with emphasis on improving living independence. This facility is operating as a permanent residence. With an apartment house available it could be altered to halfway-house operation, thereby maximizing the training for independence being supplied by the owner of this facility, Mrs. Miriam Comito.

Physical Plant, Design and Architecture

This residential facility is a forty year old two-story residence (frame stucco) with a basement and four bedrooms. It has the following recreational facilities: a garage converted to a recreation room, an indoor patio and an indoor swimming pool.

The Big R Interim (Respite) Home

201 Tamel Vista Boulevard, CorteMadera, California 94925

The Big R is operated by Marin Aid to Retarded Children and is a home away from home where educable mentally retarded and physically handicapped boys and girls who attend the

various special classes in Marin County spend three or four weeks. Its apparent relevance to some aspects of Michigan's proposed residential program for independent adult retardates, is that the Big R is a non-institutional residential facility designed to give its clients an experience in independent living and social development.

Physical Plant, Design and Architecture

This residential facility is a modern four bedroom home.

Washington

C.O.V.E. (Community Oriented Vocational Education) 918 Madison, Everett, Washington (A Vocational Rehabilitation Facility of the State of Washington).

Although this facility is a short term transitional residence to serve a preponderance of emotionally disturbed, some physically handicapped and retarded adults, the range of services provided and the community orientation are the types of services that the proposed Michigan program should examine.

Physical Plant, Design, and Architecture

This residence is designed for a client load of thirty-five. It is a 2 and one-half story structure with ten-two bedroom apartments. The building is ten years old. It is located adjacent to shopping areas and recreational facilities are nearby. It has easy access to public transportation.

Sources:

Hermstad, N.H., July and August, 1970.

Marin Aid to Retarded Children, 1970.

Europe: Denmark, Sweden, England

An examination of some Danish, Swedish and British approaches to residential facilities and supporting services merits consideration on the following factors. Non-institutionalized community based residences for the retarded have been in existence in these countries since the end of World War I. The Scandinavian service approach to the retarded resembles in some respects the regional approach to meeting needs of the mentally retarded. Their residential programs are geared to the concept of a comprehensive "mental retardation center" which bears some resemblance to Illinois' Aurora Center, and New York's Educational Guidance Center. England also has a county or regional approach to the aiding of the retarded but appears to lean toward the development of "mental retardation hostels," an approach which is gaining popularity in New York. The English, Swedish and Danish residential programs have some financial and legislative factors which have been translated or interpreted to American needs (these will be described later in this addenda). These European programs have been in existence longer than most American programs and Michigan's program may benefit from at least an acquaintance with these programs.

Lillemosegard (Copenhagen, Denmark)

Lillemosegard is the center for adult mental retardation services for Copenhagen and its services. It provides these services for approximately 300 severely, profoundly, moderate, and mild adult retardates. The residence contains 14 intramural residential units, with a variation of room size to accomodate one, two or three adults. The residents have their own furniture and some have keys to their own room. Some of the mild and moderate retarded residents are employed in sheltered workshops, competitive employment, or are employed by Lillemosegard.

The city of Copenhagen is planning a community residential center about 2.5 miles from the middle of town for about 300 moderate and mild adult retardates. About one-half of these residents will require no special assistance and will be able to live independently in the planned facilities apartment. This facility will include its own heating plant, an administrative building, shops, workshops, a kitchen building, stories, wards for acute illness, a canteen, assembly hall, church, and living units for educational activities.

Georgeshill (Horby,Sweden)

This facility was built in 1966 to house 176 severely, moderately, and mildly retarded adult men and women. This residence has six H shaped pavillions. There are 30 residents in each. Each residential unit is divided into two halves and includes, a staff office, bathrooms, and a

kitchen. Each half is then further divided by the entrances into sections of seven or eight adults each, and has a day room and dining room. There are bedrooms for one, two, or four residents in each room. A separate building houses administrative offices, an assembly hall, and sheltered workshops.

Essex County (England)

Proposed hostels and mental retardation training centers.

Essex County plans to construct six adult training centers and four hostels for retarded adults in the next seven years. Essex County feels that a very significant proportion of young mentally retarded adults would profit by the provision of individually designed courses to prepare them for life in the community or semi-independent life in a residential (hostel) unit.

Source:

Kugel and Wolfensberger, 1969.

II Number and Types of Units Proposed for the Prototype Facility

It is recommended that initially the proposed prototype should be a modular component of between 25 and 50 units (apartments). These residential units for the adult retarded could be part of a larger apartment complex housing normal and independent physically handicapped.

Types of Units

These proposed units should include a basic list of component spaces which would allow for a full range of

facilities. Each modular component should be barrier free in order to accomodate physical handicaps. These barrier free facilities are described in detail in our original proposals. Each living unit should include single or double bedrooms, a parlor, a living room, a bathroom, a small kitchen, or an extended or open (efficiency) kitchen.

The proposed residence should be basically modern in design and should be a normal type residence whose units could be converted to living facilities for elderly, physically handicapped or non-handicapped individuals who may need some sort of subsidized residential facility.

From these basic modular components, combinations might be arranged to develop a composite range of facilities which could eventually include single family residences, duplexes, four-plexes, low housing and multi-level housing. The importance of a prototype which is flexible and convertible to various components is that it can serve as a guide and illustration to possible sponsors of angencies willing to render financial and service support.

Source:

Sokoloff, Hamilton and Blewitt, Report to T. W. Coleman, September 8, 1970.

III In general,supporting services required for a non-institutionalized community residential facility for educable adult retarded should be so designed to encourage and reinforce as normal a type of living environment as the individual

degree of retardation dictates. These services should encourage independence and discourage the overdependency which some family and institutionalized environments have fostered.

List of Recommended Services
Residential and Vocational

1. Instruction or supervision in residential living.
2. Vocational training, sheltered employed, or placement in competitive employment.
3. Personal care (consultation) i.e. grooming and personal hygiene.
4. Banking and shopping
5. Laundering

A service structure providing services similar to the above must be studied and a program designed into any independent housing resource.

"The typical retardate enters the community life situation with low expectancy for success as a result of a backlog of failure experience in his previous life course---." (Selected Conference Papers, Scheerenberger, 1969, p.24) Therefore, the behavior subsumed under "social competency" must be carefully evaluated prior to any community opportunity. (Scheerenberger, p. 36)

The experts in retardation seem to agree that any community program must provide for a constellation of specialists who are conveniently available.

Diagnostic and Evaluative Services

A. Medical care
B. Dental care
C. Psychological and Social Services
D. Specialized classes for adults

Recreational

The residents of the proposed prototype should have the accessibility of the facilities available to non-handicapped individuals in a given community. In certain situations, these recreational activities may need some sort of special planning or supervision to meet the retarded adults special needs.

IV Public or Private Agencies who may be in a position to provide these Services or give Financial assistance

Public Agencies

A. Federal Agencies
   (1) The Department of Housing and Urban Development (HUD).
   (2) The Department of Health, Education and Labor (Social Security Administration)
   (3) The Department of Vocational Rehabilitation

B. State Agencies
   (1) The Department of Social Services (Michigan State Housing Development Authority)
   (2) The Department of Mental Health (Division of Mental Retardation)
   (3) The Department of Labor
   (4) The Department of Vocational Rehabilitation
   (5) The Department of Education (Division of Special Education)

Private Agencies

1. Michigan Association of Cerebral Palsy
2. Michigan Society of Crippled Children and Adults, Inc.
3. United Cerebral Palsy Association of Michigan
4. Michigan Association for Retarded Children
5. Detroit League for the Handicapped
6. The Detroit Urban League
7. The National Association of Physically Handicapped (Michigan Chapter)
8. Lodges and Fraternal Organizations such as the Kiwanis, Lions, Rotary, Elks, Masons, Shriners

It also may be advisable to consult with professional staff individuals in such facilities as the Ypsilanti State

Hospital and the Plymouth State Hospital. These individuals have had much experience working with retarded and disturbed adults and could give the Michigan residential program much useful information. Also, all of the agencies contacted during this research project might be possible supporting agencies or agencies which could give some types of consultation. These agencies are listed in the original proposals.

It is the feeling of the writers of this report that the Detroit Association for Retarded Children is interested in providing community housing for adult handicapped.

A. Comparison of the California Team Approach to Supporting Services with Wisconsin's and Illinois' Programs.

Basically the California, Wisconsin and Illinois approaches to supporting services give similar comprehensive services to the retarded. The basic differences lie in the approaches of these programs. California uses a team or educational approach, Wisconsin has a philosophy of "fixed" responsibility and Illinois uses a regional approach.

On May 27, 1966 a co-operative agreement was signed by the California Department of Mental Hygiene and Department of Rehabilitation which created a habilitation and treatment program for 500 retarded resident students. The goals of this program are to provide an individualized program of services for each resident to reach maximum development and aid them to become better adjusted productive members of the community. This would include:

A. Competitive employment
B. Sheltered employment
C. Gainful homebound work

These goals are achieved by a multi-disciplinary staff or "team" which individually tailors the rehabilitation plan for each resident student. The Rehabilitation Team is composed of an industrial, occupational recreation and music therapist, vocational counselor, special education teacher, psychiatric social worker, physician, psychologist and nursing personnel.

If one examines the Illinois Program of services for the mentally retarded and sees them in operation in one of their residential facilities, it can be seen that Illinois offers the same types of supportive services. However, there is one major difference. Illinois' program is a much larger program and covers the thousands of mentally retarded that live in that state. These services are dealt out regionally and according to specific demographic needs. Each region has a zone or regional advisory council made up of a team of professionals who decide what services, community resources, and agencies shall be involved in any continuum of services for the retarded. These programs are supervised by the Illinois Division of Mental Retardation.

Wisconsin's program also has a program which utilizes a concept of multi-disciplined approach to the rendering of services to the mentally retarded. However, it differs from California in the respect that it advocates a "shared or

fixed" responsibility of various agencies while the California team approach concentrates on individuals in professional positions rendering services to a specific retarded person. The Wisconsin program resembles the Illinois program in the respect that it is a statewide program eventually intended to serve all of Wisconsin's retarded. The California program is quite new and at this point is only serving 500 people (in their team program).

Basically, Wisconsin's program calls for shared responsibility by all levels of government, private and volunteer agencies and the general public. The Wisconsin legislation which covers the state program is described in our preliminary study/survey which has been submitted to the Michigan Department of Social Services.

Sources:

Illinois Advisory Council on Mental Retardation, 1965.

Illinois Association for the Mentally Retarded, 1968

Sloan and Scheerenberger, 1969.

Wisconsin Mental Retardation Planning and Implementation Program, 1969.

It appears that Michigan should incorporate a regional approach to meeting residential needs of the retarded and at the same time attempt to gain support services from a combination of state, federal, local, and private agencies. The types of agencies which should support Michigan's residential program or prototype for adult retardates have already been listed in this addenda.

V. Identification of Existing Programs (How the facilities were financed, services offered, and agencies involved)

Aurora Center

Financing:

This residence is a private, profit making corporation run by Unit Care Health Service Inc. of Milwaukee, Wisconsin. Unit Care runs a number of residential facilities in the United States (involving about 9000 beds) and provided the assets to purchase the "Old Aurora Hilton" for 4.1 million dollars.

After the Illinois Division of Mental Retardation approved Unit Care's program for the Aurora Center, the following financial arrangements were made. The cost of operation of the Aurora Center is $450.00 per month per resident. This includes the total cost of running the facility (i.e. staff salaries, services) and is based on ninety percent occupancy. The following state agencies assume this monthly cost:

(1) Illinois Department of Public Aid
- pays $260.00 per month of the required $450.00

(2) Illinois Department of Mental Health
- pays $190.00 per month of the required $450.00
This portion comes from after care funds (state tax money for people coming from state hospitals and training schools)

The Department of Public Aid also pays a $5.00 monthly clothing allotment and a $2.94 monthly personal allowance to each resident. There is also a Resident Benevolent Fund. This is designed for residents having no additional income.

For example, activities such as Miss Teenage Aurora are held at the Aurora Center and the proceeds go into this fund. It is hoped that those clients eventually placed in competitive employment will pay a certain amount each month toward room and board.

Services Provided:

1. Consultants (at the center)
   physician
   dentist
   psychiatrist
   pharmacist
   Unit Care consultants
   special projects

2. Professional
   Special Education Classes
   Residential Living Supervision
   Vocational Training
   Sheltered Work
   Religion
   Dietary

3. Non-Professional
   Food Service
   Housekeeping
   Maintenance
   Clerks, Typists
   Shipping &Receiving Personnel

Supporting and Consulting Agencies:

1. Illinois Department of Public Aid
2. Illinois Department of Mental Health (Division of MR)
3. Illinois Division of Vocational Rehabilitation
4. The Aurora Mental Retardation Association

Elizabeth Ludman Mental Retardation Center

This $9,000,000 State of Illinois project is sponsored and financed by the Illinois Department of Mental Health. This facility has only been in operation since August of 1970 and the $9,000,000 includes the cost of construction

and services rendered to this facility. So far no breakdown as to monthly cost per resident has been given.

Services Provided:

1. Psychological and Social Work Services
   - training in residential living
2. Clinical Services
3. Special Education Classes
4. Vocational and Recreational Training
5. Medical and Dental Services

Supporting Agencies:

1. Illinois Department of Mental Health
   a. Physical Plant Services, Division of General Services
   b. Home Economics Administrative Services
   c. Fiscal and Administrative Services
   d. Division of Mental Retardation Services

2. Consultants to the Department of Mental Health:
   a. Illinois Department of Mental Health
   b. Illinois Advisory Committee on Construction of State Residential Facilities for the Mentally Retarded
   c. National Association of Retarded Children

Sources:

Koester and Saunders, Interview 11/18/70.

Elizabeth Ludman Mental Retardation Center, 1969.

Council House

This facility is privately financed and sponsored by the Milwaukee Council of Jewish Women. The rent is approximately $105.00 per month per residential unit. Those residents working in competitive employment pool their economic resources to pay the rent and the food expenses which runs to about $18.00 per month.

Other Financial Considerations:

The Council of Jewish Women pays the staff or service people of Council House the following salaries:

1. Housemother and Housefather ($450.00 a month)
2. Student Assistant (college student - $300.00 a month)

Supporting Services:

1. Laundering
2. Cooking Classes
3. Banking and Shopping
4. Tutoring by college and high school students
5. Vocational Classes in Sewing, Woodworking
6. Recreational Facilities

Consultants to the Council of Jewish Women

1. Milwaukee Jewish Vocational Services
2. The Milwaukee Mental Retardation Association
3. The Milwaukee Jewish Center
4. The Milwaukee Police Department

Sources:

Malnekoff, Interview, 8/7/70

Work Adjustment Program, Jewish Vocational Services

Fineson House Center

Financing:

The State of New York provided the residence rent free and fully equipped. The financial support comes from the New York Department of Mental Hygiene and the National Association for Health of Retarded Children (New York City Chapter). These agencies pay all the operating expenses for Fineson House and split the expenses evenly. There is one financial loophole. Those residents who are earning less

than the minimum hourly wages get $5.00 a week and varying stipends for personal care from the New York City Department of Social Welfare. Residents competitively employed are required to pay 50% of their take home pay for room and board (which is about $70.00 a week per resident).

Services Provided:

New York State legislation under the title: Community Mental Health Retardation Facilities, Chapter 576, Sec. I. The state is allowed to establish and finance 50% or less, hostels for the mentally retarded, mentally ill, or any others which could benefit from such services. Under this legislation, Fineson House or any other hostel cannot give services which are available in the community.

Additional Agencies Providing Consultation:

1. United Cerebral Palsy Association
2. Federal Classes for the Handicapped
3. Local Chapters of YMCA and YWCA
4. Local churches and synogogues
5. Young Adult Institute
6. Lodges such as Kiwanis, Elks, Masons

Source:

Interview with Sherry Calavas, November 24, 1970.

The Educational Guidance Center for the Mentally Retarded, Inc.

Financial Considerations:

The Educational Guidance Center which hopes to open in December of 1970 will operate on the assumption that the clients or residents should be able to pay their own rents. The Residence is still looking for a financial formula but

hopes to be financed through urban renewal funds. Originally this facility was to be financed through New York's Mitchell Llama Act (state funding provision). It was decided that the clients rents would be unmanagable under this act. The $200.00 a month rent required under this act for each resident would be too much to expect. The kitchenettes in each living unit will be financed by private funds and New York Division of Vocational Rehabilitation funds.

Services Offered:

The Educational Guidance Center offers what it feels is a unique service approach to residential care for educable mentally retarded. All the services will be located within the walls of the Educational Guidance Center. All the necessary professional help will thus be located in this facility. This program will include the following services:

1. Residential Training
2. Vocational Training Program
3. Medical
4. Psychological
5. Social Services

Source:

Educational Guidance Center, 1970.

Hypothetical Facility for Marin County, California

Operating Funding:

This facility will be for retarded adults who are working competitively. Rental fees will be based on the individual's ability to pay. The deficit will be made up

by the Golden Gate Regional Center, or any other appropriate agency.

Supporting Services:

1. Marin Aid to Retarded Children
2. California Department of Mental Health
3. United Cerebral Palsy of Marin
4. Ladies Aid to Retarded Children
5. Easter Seal Society of Marin

Miriam Comito

This privately owned facility gets financial assistance from Aid to Totally and Permanently Dependent. This is a state administered program which operates with Federal funds. The Aid formula of this program and how it applies to Michigan will be described later in the addenda. Aid to Totally Dependent with financial help from the Department of Vocational Rehabilitation plus private funds and some client money (those with some employment), helps to pay the $200.00 a month needed for this facilities' residential services.

Supporting Services: (Public)

1. Aid to Totally Dependent (Federal through State)
2. Department of Vocational Rehabilitation
3. Medicare-Medical and psychiatric services

(Private)

1. Marin Aid to Retarded Children
2. Marin Easter Seal Society (Recreational)
3. Ross General Hospital (Employes two clients)

The Big R Interim Respite Home

Financial Considerations:

The annual operating budget is $28,000. The Big R is

operated and financed by a special operating committee of the following agencies:

1. Marin Aid to Retarded Children
2. Marin Easter Seal Society
3. United Cerebral Palsy
4. Golden Gate Regional Center
5. Department of Social Services
6. State Department of Social Welfare
7. The Marin Charitable Foundation
8. Irvine Foundation
9. The Babcock Foundation (Donating foundation, initial outlay of $13,000)

Services:

1. Gives interim experience to its clients in independent living and social development
2. Counseling of parents
3. Psychological services
4. Medical services
5. Nutritional services
6. Special Education classes

C.O.V.E. (Community Oriented Vocational Education)

Funding Considerations:

This facility was funded through the federal Social and Rehabilitation Service Project Grant RD, 1940-G, Department of Health, Education and Welfare, which planned the period of August 1, 1965, to July 31, 1969.

Services Provided:

This facility provides dependent handicapped adults (some mentally retarded) with a residence, social educational developmental opportunities, as well as vocational exploration and evaluation on a series of job tryouts in community work stations.

Sources:

Marin Aid to Retarded Children, 1970

Hermstead, 1970

Sokoloff, 1970

Llemosegard

Financing:

This facility is funded by the Danish Mental Retardation Act of 1959. With this act, the Mental Retardation Service has been established as a semi-independent organization under the jurisdiction of the Ministry of Social Affairs. This service system for the mentally retarded is divided into 12 regions, each region being administered by a center such as Llemosegard (Copenhagen Region).

The Llemosegard Residence is an old facility which was remodeled and modernized from 1960-1964. Remodeling costs were the following: 22 million Dan. Kr. ($2,933,333;/ $5,866,667 or 73,000 Dan. Kr. $9.733/$19,467) per resident. Maintenance cost per year per resident is 27,000 Dan. Kr. ($3,600;/$7,200).

Services:

1. Offers sheltered employment
2. Residential care services
3. Vocational placement and training
4. Special Education classes

Georgeshill

This facility was built in 1966 at a cost of $225 million

dollars or about $13,000 per resident. The 1968 operating budget at Georgeshill was $1,100,000 per resident this amounts to $6,150 per annum and $17,000 per diem. All the necessary services are provided at this facility. The staff exclusive of consultants consists of 95 persons with a resident staff ratio of 1.85.

In Sweden, facilities such as Georgeshill are financed by the national government under the direction of the National Board of Education and the National Board of Health and Welfare. Residential care for the mentally retarded is defined in the national legislation of 1968. This legislation states that residential institutions, special hospitals, day centers for children shall be provided for the retarded. Mentally retarded who need care according to this law but who do not need care in an institution shall be provided with care in their own homes or care in some other type of residential facility. Section 5 of this law is very important and bears some significance to Michigan's needs. It states that accomodations in other private homes, boarding homes shall be provided for those retarded who do not need to live in a residential care institution or a special hospital. The philosophy of this legislation is that it is just as normal for an adult (M.R.) to live independently as it is for a child to live with his parents. Thus, society has to provide other accomodations as close to normal as possible.

Essex County's Proposed Hostels

The British feel that is it less expensive to have smaller facilities than it is to construct one large institutional residence for the retarded. For example, a new 450 bed hospital costs 2.5 million pounds. Building hotels containing the same number of beds would cost only 1.3 million pounds. Current cost of keeping a retarded adult in one of Essex County's residential units is 18 pounds or $45.00 per week.

Source:

Kugel and Wolfensberger, 1969.

VI Answered previously in this addenda.

Federal Legislation (possible availability of federal financing)

P.L. 88-164 "The Mental Retardation Facilities and Mental Health Construction Act of 1963"

This federal legislation authorized an appropriation of 329 million over a five year period to provide: grants for construction of mental retardation facilities; grants for training professional personnel in the education of the handicapped and grants for conducting research relating to the education of the handicapped.

Title I, Part A: Authorized grants for the construction of public non-profit centers for research that would develop knowledge for combating and preventing mental retardation.

Title I, Part B: Authorized grants for construction of clinical facilities for the mentally retarded, associated with a college or university which would provide as nearly as practical, a full range of in-patient and out-patient services.

Title I, Part C. Authorized federal grants to states to assist in the construction of specially designed public and non-profit facilities to provide diagnosis, treatment, education, training, personal care, and sheltered workshops for the retarded.

The Mental Retardation Amendments of 1967.

P. L. 90-170 provided for a new grant program to pay a portion of the costs for compensation of professional and technical personnel in community facilities for the mentally retarded.

Title I, Part C, thus, is administered by the Division of Mental Retardation, Rehabilitation Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare.

The State of Michigan has three facilities for the retarded approved under this federal legislation. The state agency responsible for community mental retardation facilities construction program in Michigan is the Department of Public Health, Lansing, Michigan. In 1968, Michigan received $435,417 and the 1969 and 1970 estimates are $440,252 and $260,286 respectively.

Michigan Facilities Operating Under Title I, Part C (P.L. 88-164)

1. Clare-Gladwin Day Center - Clare, Michigan

   Type of facility:
   Public - day facility

   Services:
   a. Diagnosis and evaluation
   b. Treatment
   c. Education
   d. Training
   e. Personal care

Numbers served: 44

Age Groupings: preschool and school

Levels of Retardation: moderate and severe

Estimated cost: $239,000

Federal share: $124,000

2. Marvin E. Beekman Center - Lansing, Michigan

Type of facility:
Public - evaluation and training center

Services:
a. Diagnosis and evaluation
b. Treatment
c. Education
d. Training
e. Personal care
f. Sheltered workshop

Numbers served: 268

Levels of Retardation: moderate, severe, profound

Age Groupings: preschool, school, adult

Estimated cost: $1,486,000

Federal share: $619,000

3. Western Michigan's Mental Retardation Center - Muskegon Michigan

Type of facility:
Public - day and residential

Services:
a. Diagnosis and evaluation
b. Treatment
c. Education
d. Training
e. Personal care

Numbers served: 650

Levels of Retardation: Mild, moderate, profound

Age Groupings: preschool, school, adult

Estimated cost: $4,833,000

Federal share: $656,000

Source:

Mental Retardation Construction Program, 1969

Other Relevant Federal Legislation:

Aid to Permanently and Totally Disabled (APTD)

Federal grants to states for a program of aid to permanently and totally disabled were provided under the Social Security Act Amendments of 1950. All states except Nevada now have APTD programs operating with federal assistance.

The general requirements set forth in the Social Security Act for Old Age Assistance (OAA) and Aid to Blind (AB) apply to APTD. The needy person must also be at least 18 years old and be permanently or totally disabled. The states must set their own definition of permanent and total disability, being guided by the Federal interpretation that sets maximum limitations of coverage for purposes of federal financial participation. Generally, there must be a physical or mental impairment, verifiable by medical findings, that is expected to continue indefinitely and that substantially prevents a person from engaging in any useful occupation either as a wage earner or homemaker. Factors such as age, training experience, and social setting are taken into account in determining disability. Some states provide that the impairment must be one that is not likely to be improved by therapy. The disability determination must be made by a team

of specialists, including a doctor, a social worker, and in some states, a vocational rehabilitation counselor. In December, 1967 the average money payments in state programs ranged from $46 a month in Mississippi to $127 in Iowa. The average money payment per recipient in all the states was $81.00.

The cost of assistance programs under the Social Security Act is shared by federal, state, and local governments. The formula for computing the federal share of OAA payments for states that have a medical assistance (MA) program is 31/37ths of the first $37 of a maximum average monthly payment of $75. per recipient plus a proportion of the next $38. of such payment. Federal financial participation for AB and APTD programs is similar to that for OAA, if the state has an MA program.

In order for an APTD individual to get aid directly from the federal program, he must have worked a sufficient amount of time. Those individuals in Michigan who do not fulfill these work requirements (most mentally retarded would fall into this category), would need to get allotments from the Department of Health under the direction of the Department of Social Services.

If one considers the total program in Michigan (OAA, AB, MA, and APTD). The average monthly payment is $145.00. The Federal share is $60.00 of this $145.00 monthly payment.

Sources:

Social Security Handbook, 1969.

Social Security Programs in the United States, 1968.

Vocational Education Amendments of 1968

P.L. 90-576

This law amends the Vocational Education Act of 1963 but retains the state grant provision on a continuing basis and authorizes new programs for five years. These authorizations are for state vocational education programs and research and training in vocational education. There are also special authorizations for certain categorical programs.

Major Provisions

This legislation provides that any state which desires to receive a grant for any fiscal year shall establish a State Advisory Council. The responsibilities shall include:

1. Advising the State Board on the development of, and policy matters, in the administration of the state plan.
2. Evaluating vocational education programs, services, and activities and publishing the results thereof.
3. Preparing and submitting through the State Board to the Commission of Education and the National Council an annual evaluation report.

This legislation defines handicapped as follows: "Means persons who are mentally retarded, hard-of-hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled...."

P. L. 90-391

This amendment extends through the fiscal year 1971 the authorizations for appropriations for Section 2 grants to states for vocational rehabilitation centers. $700 million is authorized for allotment among states in 1971. The Federal share is increased to 80 per cent, effective fiscal year 1970. Some provisions which could have significance to Michigan's residential program for the adult retarded are:

1. Establishment of Minimum Allotments to States:

   To increase efficiency, expand rehabilitation services and reach a greater number of clients, a base of $1 million has been fixed under Section 2 to assist States in achieving these goals.

2. Construction of Rehabilitation Facilities:

   Provides that Section 2 funds may be utilized for new construction as well as expansion...of existing buildings. A limitation of 10 per cent of Section 2 allotments has been established for financing new construction.

3. Grants to States for Special Projects:

   The Amendments extend the authorization for specialized projects in the areas of research, demonstration, expansion, and training of rehabilitation personnel (projects for rehabilitation service to the retarded is included).

4. Construction:

   If a state plan includes provision for construction of rehabilitation facilities, it must not contemplate construction when the federal payment exceeds 10 per cent of the state's allotment. In addition, federal standards and the Hill-Burton matching rates applicable to construction in Section 12 of the Vocational Rehabilitation Act will be applicable to new construction with Section 2 funds.

Sources:

A Summary of Selected Legislation Relating to the Handicapped, U.S. Department of Health, Education, and Welfare, 1968.

Michigan Legislation Dealing with Construction and Administration of Residential Facilities for the Mentally Retarded:

As already mentioned in this addenda, the Michigan Department of Public Health has constructed and is administering three facilities for the mentally retarded under the federal legislation P.L. 88-164, and P.L. 90-170.

Under Section IX of Michigan's Mental Health Statutes, there are provisions for the establishment of community mental health programs for mentally ill or in some cases mentally retarded. The highlights of this legislation includes:

> The Department of Mental Health may make matching grants to assist cities of 500,000 or more population, or any county or combination of counties, or a combination of a county and a city therein with a population of not less than 500,000 in the establishment and operation of local mental health programs which provide the following services:
>
> (a) Diagnosis and treatment of mentally disabled persons by means of appropriate facilities and services...
>
> (b) Collaboration and consultation with community agencies including but not limited to public and non-public schools...welfare agencies, etc.

Source:

Michigan Department of Mental Health, State of Michigan Mental Health Statutes, 1969.

VII Required State Legislation for Participating in the Federal Funding Program or to Support the Prototype:

It is recommended that the Michigan legislature create an independent Division of Mental Retardation which should be organized on a basis similar to the Illinois Division of Mental Retardation which divides Illinois into eight regional or mental retardation zones. Each zone could be defined in terms of residential needs, employability, number of retardates, and degree of retardation. Federal and state funding programs are more likely to support a state residential program or programs that are well planned and whose client's needs are well defined. A Division of Mental Retardation would facilitate and coordinate plans for effective residential facilities and support services for adult mentally retarded who need some type of non-institutionalized living environment. As already mentioned, the Federal Department of Health, Education, and Welfare, and the Michigan Departments of Public Health and Social Services are involved in giving financial assistance to some construction programs for the mentally retarded and aid to permanently and totally disabled adults with little or no employment capabilities.

With effective organization of service and residential needs of adult mentally retarded on the state level it may be possible to elicit financial support from federal agencies such as H.U.D., other Departments of State, and private philanthrophic organizations.

Necessary to any legislation on the state level pertaining to the construction of non-institutionalized residences for adult retardates are specific licensing standards and definitions pertaining to community living residential facilities for the adult mentally retarded.

VIII Summation of Addenda

It must be said, in summation, that there are no specific precedents for housing for the adult mentally retarded as it is envisioned for Michigan. Because of the lack of experiential resources in this unexplored area rather than in spite of them, Michigan has an opportunity as well as an obligation to initiate a pioneer facility and program.

Of the many principles that must be acknowledged in "designing" such a program/facility the following should be continually kept in the forefront of the minds of the planners:

1. A process must be provided for carefully evaluating the behavior subsumed under "social competency" prior to any independent community opportunity.
2. The traditional constellation of services of those specialists usually associated with mental retardation must be conveniently available e.g., psychologist, social work (counseling) and vocational rehabilitation.
3. In addition to the specialized agencies traditionally concerned with the retarded the existing generic agencies (traditional agencies not specifically for the retarded) must extend their definition and service, e.g. public health, social welfare, state employment resources, etc.

4. Michigan must sincerely and materially move toward a principle similar to the Swedish "normalization law" of July 1, 1968. "---the mentally retarded who need care according to law but who do not need care in an institution--- shall be provided with care in their own homes." "---accomodation in other private homes, boarding homes, as student hostels shall be provided for those mentally retarded who cannot stay in their own homes but who do not need to live in residential care institutions or a special hospital.

5. Any facility/program must offer the greatest amount of independence and integration to the individual. (Dr. Bengt Nirge and David Sokoloff). When the individual no longer needs special services he should no longer be considered retarded.

6. Involvement with his own peers can be supportive to the handicapped individual hence provision should be made to allow for this kind of normal exchange but we must observe the fine line between "integrating" facilities and "segregating" facilities which perpetuate inappropriate conceptualization of the mentally retarded by the public. (Sokoloff, et. al.)

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APPENDIX

1966 Daily Maintenance Expenditures in Institutions for the Mentally Retarded, by State and Number of Residents per 10,000 Population

State	Daily Maintenance Cost per Resident	Rank	Residents per 10,000 Pop.	Rank
Alaska	$22.38	1	-	-
Kansas	12.18	2	8.81	31
New Mexico	12.11	3	6.07	41
California	11.41	4	7.11	37
Rhode Island	10.64	5	10.56	20
Wisconsin	10.63	6	9.06	29
Connecticut	8.82	7	13.70	15
West Virginia	8.78	8	2.61	49
Maine	8.66	9	10.20	22
Colorado	8.55	10	10.01	24
Kentucky	8.44	11	3.46	47
Hawaii	8.31	12	12.17	16
Louisiana	8.23	13	6.36	40
Michigan	8.07	14	15.03	10
Oklahoma	8.05	15	8.43	33
Iowa	7.97	16	6.78	38
Maryland	7.72	17	8.43	32
Illinois	7.54	18	9.20	28
Georgia	7.47	19	4.37	46
Indiana	7.42	20	8.04	34
Washington	7.36	21	14.01	14
Florida	7.32	22	7.61	36
Delaware	7.17	23	11.45	18
Idaho	7.13	24	10.54	21
New Jersey	7.13	25	9.49	27
Pennsylvania	7.09	26	10.05	23
Arkansas	7.07	27	3.38	48
Oregon	7.02	28	14.79	12
New York	6.94	29	15.02	11
North Carolina	6.92	30	8.97	30
Massachusetts	6.69	31	16.09	8
District of Columbia	6.58	32	16.28	7
Wyoming	6.50	33	22.00	1
Missouri	6.36	34	5.70	42
Minnesota	5.95	35	15.34	9
Tennessee	5.92	36	5.39	45
Utah	5.86	37	10.94	19
Vermont	5.76	38	16.37	6
New Hampshire	5.60	39	16.76	4
Arizona	5.38	40	5.56	44
Ohio	5.08	41	9.71	25
Montana	5.00	42	14.73	13
Texas	4.88	43	9.61	26
Virginia	4.71	44	8.02	35
North Dakota	4.39	45	18.90	3
Alabama	4.04	46	6.45	39
South Carolina	3.90	47	11.82	17
Nebraska	3.58	48	16.45	5
South Dakota	3.17	49	19.33	2
Mississippi	2.30	50	5.62	43

*Adapted from Provisional Patient Movement, 1967.

APPENDIX

State Residents in Institutions for the Mentally Retarded per 10,000 Population, by State, and Daily Maintenance Expenditures

State	Institution Residents per 10,000	Rank	Daily Maintenance Cost per Resident	Rank
Wyoming	22.00	1	$6.50	33
South Dakota	19.33	2	3.17	49
North Dakota	18.90	3	4.39	45
New Hampshire	16.76	4	5.60	39
Nebraska	16.45	5	3.58	48
Vermont	16.37	6	5.76	38
District of Columbia	16.28	7	6.58	32
Massachusetts	16.09	8	6.69	31
Minnesota	15.34	9	5.95	35
Michigan	15.03	10	8.07	14
New York	15.02	11	6.94	29
Oregon	14.79	12	7.02	28
Montana	14.73	13	5.00	42
Washington	14.01	14	7.36	21
Connecticut	13.70	15	8.82	7
Hawaii	12.17	16	8.31	12
South Carolina	11.82	17	3.90	47
Delaware	11.45	18	7.17	23
Utah	10.94	19	5.86	37
Rhode Island	10.56	20	10.64	5
Idaho	10.54	21	7.13	24
Maine	10.20	22	8.66	9
Pennsylvania	10.05	23	7.09	26
Colorado	10.01	24	8.55	10
Ohio	9.71	25	5.08	41
Texas	9.61	26	4.88	43
New Jersey	9.49	27	7.13	25
Illinois	9.20	28	7.54	18
Wisconsin	9.06	29	10.63	6
North Carolina	8.97	30	6.92	30
Kansas	8.81	31	12.18	2
Maryland	8.43	32	7.72	17
Oklahoma	8.43	33	8.05	15
Indiana	8.04	34	7.42	20
Virginia	8.02	35	4.71	44
Florida	7.61	36	7.32	22
California	7.11	37	11.41	4
Iowa	6.78	38	7.97	16
Alabama	6.45	39	4.04	46
Louisiana	6.36	40	8.23	13
New Mexico	6.07	41	12.11	3
Missouri	5.70	42	6.36	34
Mississippi	5.62	43	2.30	50
Arizona	5.56	44	5.38	40
Tennessee	5.39	45	5.92	36
Georgia	4.37	46	7.47	19
Kentucky	3.46	47	8.44	11
Arkansas	3.38	48	7.07	27
West Virginia	2.61	49	8.78	8
Alaska	-	-	22.38	1

*Adapted from Provisional Patient Movement, 1967.