Vocational rehabilitation of the mentally retarded
Vocational rehabilitation of the mentally retarded

Proceedings, conclusions and recommendations of a Seminar on Vocational Rehabilitation of the Mentally Retarded, held in Kingston, Jamaica, from 4 to 15 September, 1978. It was organised by the Governments of Jamaica and Denmark and the International Labour Office in collaboration with the Caribbean Institute on Mental Retardation and Developmental Disabilities (the technical arm of the Caribbean Association for Mental Retardation). The project was financed by the Danish International Development Agency (DANIDA).

International Labour Office   Geneva
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INTRODUCTION

ILO Recommendation No. 99 concerning vocational rehabilitation of disabled persons indicates that vocational rehabilitation services should be made available to mentally as well as physically disabled persons. Most countries, however, have concentrated initially on providing rehabilitation services for the orthopaedically handicapped, the blind and the deaf. Only in recent years, thanks to the efforts of such organisations as the International League of Societies for the Mentally Handicapped, have the rights of the retarded begun to be recognised with governments realising that mental retardation presents enormous problems in the health, welfare and educational sectors. In the employment field, thanks to recent research and pilot projects in Eastern and Western Europe, the United States, Israel and other countries the employment potential of even the severely retarded for a wide range of jobs has been conclusively demonstrated. Indeed, many severely and moderately retarded persons whose problems of social adaptation have been resolved through pre-vocational preparation, including careful and patient training in activities of daily living, are performing tasks of much greater complexity than was hitherto thought possible.

Estimates of the prevalence of mental retardation vary from 1 to 3 per cent of the population, but such estimates include the mildly retarded (they account for some 75 per cent of all cases) who may encounter problems in the schooling years but can eventually be integrated without much difficulty into a normal social and employment setting. It is the moderately and severely retarded who require special help and training and they represent 0.5 per cent of any population group. Nevertheless, the problem of mental retardation is increasing; as medical services are extended and improved, the severely retarded have a greater life expectancy. Expanding education services in developing countries are revealing what was hitherto a hidden problem; moreover, in the Third World, the old tradition of family care for the retarded is breaking down and state help and support is being sought for the retarded on a growing scale.

With the above considerations in mind, the International Labour Office, with the generous support of the Danish International Development Agency and the Government of Jamaica decided to hold a Caribbean Regional Seminar on the Vocational Rehabilitation of the Mentally Retarded. The Caribbean region was selected because of the active interest of countries in that region in developing rehabilitation services for the retarded through the Caribbean Association for Mental Retardation and its technical arm, the Caribbean Institute on Mental Retardation and Developmental Disabilities.

In particular, the Seminar was designed to provide planners and professional staff of government and non-government services engaged in establishing rehabilitation programmes for the mentally retarded in Caribbean and neighbouring countries with the opportunity to:

1. WHO, Technical Report Series No. 392, "Organisation of services for the mentally retarded".
(i) study the organisation, administration and operation of vocational rehabilitation services for the mentally retarded within the over-all programme of rehabilitation and services for other disabled groups and for the general population;

(ii) obtain new ideas, fresh views, methods and techniques on the development of employment opportunities for the mentally retarded and to consider how best they can be applied to their own countries;

(iii) exchange information on rehabilitation programmes and the problems encountered or envisaged in developing such programmes for the mentally retarded in the countries represented.

The Seminar was held in Kingston, Jamaica from 4 to 15 September 1978. It was hosted by the Government of Jamaica through its Ministry of Social Security and organised as part of the joint technical co-operation programme of the ILO and the Danish International Development Agency (DANIDA).

The Director-General of the International Labour Office extends grateful thanks to the Governments of Denmark and Jamaica for their generous support of the project. In particular, he wishes to express deep appreciation of the splendid contributions made by Dr. M.J. Thorburn and Mr. N.E. Bank-Mikkelsen, respectively the Jamaican and Danish Co-Directors of the Seminar. Thanks are also due to the Minister, Permanent Secretary and staff of the Ministry of Social Security, Government of Jamaica for their active interest and support; also the many Jamaican organisations who contributed to the programme and provided such generous hospitality - the Caribbean Association for Mental Retardation and its Caribbean Institute on Mental Retardation, the Jamaica Council for the Handicapped, the Jamaica Association for Mentally Handicapped Children, the Salvation Army; the secretarial and supporting staff, the Jamaican and international lecturers as well as the officials of the rehabilitation centres and facilities visited during the course of the Seminar.

The valuable support and assistance provided to the programme by the International League of Societies for the Mentally Handicapped and the International Council of Goodwill Industries is also gratefully acknowledged.

It is hoped that the report which follows will be of value and assistance not only to governments and non-governmental organisations of the participating countries, but also to all countries which are planning to develop vocational rehabilitation services for their mentally retarded people.

The report consists of four chapters:

Chapter 1 - Organisation and administration of the Seminar

Chapter 2 - Programme and activities

Chapter 3 - Conclusions of the Seminar

Chapter 4 - A selection of lecture and country papers presented at the Seminar.
CHAPTER 1

Organisation and administration of the Seminar

Technical preparation

The Seminar programme was drawn up early in 1978 following a visit to Jamaica by Mr. N. Phillips, the ILO Caribbean Regional Vocational Rehabilitation Adviser. Dr. M.J. Thorburn, Director of the Caribbean Institute on Mental Retardation and Developmental Disabilities was nominated as Jamaican Co-Director of the Seminar and together with officials of the Ministry of Social Security, the Jamaica Council for the Handicapped and other local organisations was responsible for all local arrangements. Administrative arrangements for the Seminar, including recruitment and travel of participants, were handled by the ILO Caribbean Office, Port-of-Spain, Trinidad, whilst international lecturers were recruited by ILO headquarters, Geneva.

The directing staff of the Seminar consisted of:

Dr. M.J. Thorburn - Jamaican Co-Director, Director, Northern Caribbean Unit, Caribbean Institute on Mental Retardation and Developmental Disabilities, 94C Old Hope Road, Kingston 6, Jamaica.

Mr. N.E. Bank-Mikkelsen - Danish Co-Director, Director, National Board of Social Welfare, 6 Kristineberg, Postbox 2555, 2100, Copenhagen Ø, Denmark.

Mr. N.E. Cooper - ILO Co-Director, Chief, Vocational Rehabilitation Section, International Labour Office, CH 1211 Geneva 22, Switzerland.

Mr. N. Phillips - ILO Caribbean Regional Vocational Rehabilitation Adviser, ILO Caribbean Office, P.O. Box 1201, Port-of-Spain, Trinidad and Tobago.

The Seminar was based at the Courtleigh Manor Hotel, New Kingston, where staff and participants were accommodated.
Participants

Fifteen countries from the Caribbean and neighbouring region sent 23 participants to the Seminar:

Antigua

Mr. C.J. Roberts,
Chairman,
Antigua Association for the Handicapped,
P.O. Box 752, Market Street,
St. Johns.

Bahamas

Mrs. C.J. Dean,
Assistant Teacher,
Stapledon School for Mentally Retarded Children,
P.O. Box N.8418,
Nassau.

Barbados

Mrs. J.O. Burnett,
Workshop Supervisor,
Challenor School,
Canefield House,
St. Thomas.
Miss M. Nicholls,
Placement Officer,
Ministry of Labour and Community Services,
Bridgetown.

Mrs. C.C.O. Walcott,
Senior Teacher, Charles Broome School for the Mentally Retarded,
St. Michael.

Belize

Mrs. L.A. Lopez,
Acting Principal,
Lynne School,
22 West Canal Street,
Belize City.

Bermuda

Mr. N. Caines,
Supervisor,
Opportunity Workshop, Prospect,
P.O. Box 1550,
Hamilton 5.

Colombia

Miss M. Zalzman,
Director, Institute for Vocational Rehabilitation and Special Education,
Carrera 5, N.26-39, Ap. 706,
Bogotá.

Costa Rica

Mr. J.A. Astacio P.,
Executive Director,
Vocational Rehabilitation Institute,
Ap. No. 6213,
San José.
Dr. C. Mora,
President, National Council on Rehabilitation and Special Education,
Ap. 1425,
San José.

Grenada
Miss M. Charles,
Nurse-in-Charge, Kennedy School for Handicapped Children,
Richmond Hill,
St. George.

Guyana
Miss R. Campbell,
Social Worker, David Rose School for Handicapped Children,
Georgetown.

Haiti
Miss G. Wolff,
Instructor, Rehabilitation Programmes,
Ecole St. Vincent, Box 415,
Port-au-Prince.

Jamaica
Mr. I.M. Aiken,
Principal Rehabilitation Officer,
Jamaica Council for the Handicapped,
91A Old Hope Road,
Kingston.

Mrs. L. Buchanan,
Administrator, School of Hope,
Jamaica Association for Mentally Handicapped Children,
Box 224,
Kingston.

Miss V.M. Burnett,
Placement Officer,
Jamaica Council for the Handicapped,
91A Old Hope Road,
Kingston.

Mrs. M.E. Mack,
Executive Secretary,
Jamaica Council for the Handicapped,
91A Old Hope Road,
Kingston.

Netherlands Antilles
Mr. S. Englehardt,
Social Worker,
Special Schools Department,
Brakkepul NST 124,
Curaçao.

Mr. R. Pardo,
Project Leader,
Social Workshops,
Navajosweg #15,
Curaçao.
St. Lucia

Miss M.E.R. Yorke,
Teacher - Educator,
St. Lucia Teachers' Training College,
Ministry of Education,
Moïne Fortuné, P.O. Box 106,
Castries.

St. Vincent

Mr. E. Stephens,
President, St. Vincent Association
for the Handicapped,
P.O. Box 436,
Kingston.

Trinidad and Tobago

Mrs. N. Patrick,
Principal, School for Mentally
Handicapped Children,
7 Fourth Street,
Mount Lambert,
Port-of-Spain.

Miss S. Richardson,
Occupational Therapist,
St. Ann's Hospital,
Port-of-Spain.

Lecturers

In addition to the directing staff, the following lecturers presented papers at the Seminar:

Mr. A.N. Leslie - Permanent Secretary,
Ministry of Social Security,
Kingston,
Jamaica.

Mrs. M. Brown - Principal, School of Hope,
Jamaica Association for Mentally
Handicapped Children,
Box 224,
Kingston,
Jamaica.

Dr. E. Chigier - National Secretary, Israel Society
for Rehabilitation of the Disabled,
10 Ibn Gvirol Street,
Tel Aviv,
Israel.

Dr. A. Neufeldt - Director, National Institute on
Mental Retardation,
Kinsmen NIMR Building,
York University Campus,
4700 Keel Street,
Downsview, Toronto,
Ontario M3J 1P3,
Canada.

Dr. G. Soloyanis - Director, International Operations, International Council, Goodwill Industries, 9200 Wisconsin Avenue, Washington, D.C. 20014, USA

Dr. E. Whelan - Hester Adrian Research Centre, University of Manchester, Manchester M16 9PL, England.
CHAPTER 2

Programme and activities

Opening ceremony

The Seminar was formally opened on 4 September 1978 at the Courtleigh Manor Hotel by the Hon. Winston Jones, Minister of Social Security, Government of Jamaica. Mr. A.N. Leslie, Permanent Secretary of the Ministry of Social Security chaired the ceremony and other addresses of welcome were given by the Seminar Co-Directors, Mr. K. Binns, Chairman of the Jamaica Council for the Handicapped and Mr. A. McLeod, Chairman of the Jamaica Association for Mentally Handicapped Children.

Programme

The detailed programme of the Seminar was as follows:

Sunday, 3 September

Arrival and registration of participants

Monday, 4 September

09.00-10.30 Official opening

11.00-12.30 Mental retardation in the Caribbean: problems and solutions (Dr. M.J. Thorburn)

13.30-15.00 The concept of normalisation in mental retardation (Mr. N.E. Bank-Mikkelsen)

15.30-17.30 Group and plenary discussions

Tuesday, 5 September

08.30-10.30 Presentation of country papers

11.00-11.30 Film: “They all can work” (Canadian film on employment of the mentally retarded)

11.30-12.30 Jamaica’s vocational rehabilitation programme for the disabled (Mr. A.N. Leslie)

14.00-15.00 Assessment of mental capacity: some issues and some methods (Dr. M.J. Thorburn)

15.30-17.30 Group discussions and presentation of country papers

Wednesday, 6 September

08.30-10.15 Job analysis and the techniques of training the mentally retarded (Dr. E. Whelan)

10.30-12.30 International co-operation - a panel discussion (Mrs. Y. Posternak, Dr. G. Soloyannis and directing staff)
14.00-15.30  **Job analysis** (continued) (Dr. E. Whelan)
16.00-17.30  Group discussions

**Thursday, 7 September**

08.30-10.15  **Transition of the mentally retarded from special school to work** (Mrs. H. Broun)
10.30-12.30  Visits to School of Hope, Office Training Centre, Assessment and Guidance Centre
14.00-14.30  "Try another way" - films on preparing and training the severely retarded (Dr. Marc Gold - USA)
14.30-15.30  **Job analysis** (continued)
16.00-17.30  Presentation of country papers

**Friday, 8 September**

08.30-10.30  **Comprehensive vocational service systems for mentally retarded people** (Dr. A. Neufeldt)
11.00-12.30  **Training of personnel for mental retardation programmes** (Dr. A. Neufeldt)
14.00-15.30  **The role of parent and volunteer organisations** (Mrs. Y. Posternak)
16.00-17.30  Group discussions

**Saturday, 9 September**

09.00-10.30  "Try another way" - continuation of film series (Dr. Marc Gold)

**Sunday, 10 September**

Free

**Monday, 11 September**

08.30-10.00  **Training and employment of the mentally retarded in agriculture** (Dr. E. Chigier)
10.00-10.30  "Ordinary work" - Israeli film showing how a group of severely retarded were prepared and trained for work in citriculture and horticulture
11.00-12.30  **Outlets in normal employment for the retarded** (Dr. E. Chigier)
13.30-15.30  Group discussions
16.00-17.30  Presentation of country papers
Tuesday, 12 September

08.30-10.00 Group work with the mentally retarded
    (Dr. E. Chigier)
10.00-10.30 "Group work by retarded in Israel" - film
11.00-12.30 General discussion
13.30-15.00 The role of employment in the socialisation of mentally retarded persons (Dr. G. Soloyanis)
15.30-16.30 Description of the Salvation Army's new workshop for the handicapped
16.30-17.30 Group discussions

Wednesday, 13 September

09.00-12.30 Group visits to special education and early stimulation projects
13.30-17.30 Free

Thursday, 14 September

08.30-09.15 ILO approaches and programmes in the field of vocational rehabilitation of the disabled
    (Mr. N. Phillips and Mr. N.E. Cooper)
09.15-10.30 ILO rehabilitation film "Back to life" and presentation of ILO sound/slide audio-visual presentation on "Vocational rehabilitation of the disabled"
11.00-12.30 General discussion on statistics and training programmes of the Caribbean Institute on Mental Retardation and Developmental Disabilities
13.30-15.00 Group discussions
15.30-17.30 Preparation and review of final conclusions and recommendations

Friday, 15 September

09.00-10.30 Adoption of final conclusions and recommendations
10.30-11.00 Formal closure

Working methods at the Seminar

As will be seen from the foregoing programme outline, following a general review of rehabilitation services for the disabled in general and the mentally retarded in particular, both in Jamaica and the Caribbean region as a whole, the lecture programme covered important subjects such as the principle of normalisation, the transition from school to work, the role of parent and volunteer organisations, staff training and international co-operation.
Special emphasis was laid on job and task analysis, preparing and training the retarded for group work in urban and rural areas, integration in a normal work setting and in sheltered employment. Most lecture subjects were illustrated by films; visits to local centres and facilities for the mentally retarded also enabled participants to see the practical implementation of the ideas and concepts discussed.

**Group work**

Throughout the Seminar, participants were divided into three working groups to allow for a thorough examination of each main subject in the programme. Each group had its own chairman and rapporteur. The conclusions reached by each group were presented orally by group rapporteurs in plenary session and then summarised daily by the directing staff. The summaries formed the basis for the final conclusions and recommendations adopted at the final session of the Seminar (see Chapter 3).

The composition of the working groups was as follows:

**Group A**

- Mr. C.J. Roberts - Antigua (Chairman)
- Mrs. C.C.O. Walcott - Barbados (Rapporteur)
- Mrs. L. Buchanan - Jamaica
- Mrs. C.J. Dean - Bahamas
- Mr. R. Pardo - Curacao
- Miss S. Richardson - Trinidad
- Miss M. Zalzman - Colombia

**Group B**

- Mr. E. Stephans - St. Vincent (Chairman)
- Miss M.E.R. Yorke - St. Lucia (Rapporteur)
- Mr. J.A. Astacio - Costa Rica
- Miss J.O. Burnett - Barbados
- Miss R. Campbell - Guyana
- Mr. S. Englehardt - Curacao
- Mrs. L.A. Lopez - Belize
- Mrs. M.E. Mack - Jamaica

**Group C**

- Mrs. W. Patrick - Trinidad (Chairman)
- Miss V. Burnett - Jamaica (Rapporteur)
- Mr. I.M. Aiken - Jamaica
- Mr. N. Caines - Bermuda
- Miss M. Charles - Grenada
- Dr. C. Mora - Costa Rica
- Miss M. Nicholls - Barbados
- Miss G. Wolff - Haiti

**Lecture and country papers**

Copies of the lecture and country papers were distributed to participants throughout the course of the Seminar. Each participant
had been invited, prior to the Seminar, to prepare a short paper describing his or her country’s programmes and services concerned with the rehabilitation of the mentally retarded. A selection of lecture papers and country papers is included in Chapter 4.

Assessment

All who participated in the Seminar were of the opinion that it had been well worth while and that the aims and objectives had been achieved. Many new ideas and innovative techniques of rehabilitating the mentally retarded came to light. Moreover, many misconceived ideas were discounted; in particular, it was recognised that the majority of severely disabled retarded are not unemployable but can, with careful and patient preparation and training, undertake a wide range of work in both urban and rural areas. Great stress was laid on the need to recognise the human rights of the retarded. The principle of normalisation was fully endorsed (Conclusions 3 to 7). The importance of task analysis was recognised (Conclusions 14 to 19) and methods of widening employment opportunities for the retarded including the need to reorganise sheltered workshops were suggested (conclusions 24 to 34). Finally, all governments of the Caribbean region were urged to give higher priority to programmes of rehabilitation for the mentally retarded, and in developing their programmes, to seek the help of the Caribbean Institute on Mental Retardation and Developmental Disabilities, the United Nations, the ILO and other specialised agencies (WHO and UNESCO), national and international non-governmental organisations concerned with the mentally retarded (Conclusions 35 to 38).
CHAPTER 3

Final conclusions

The following conclusions were unanimously adopted by participants at the final review session of the Seminar. They take into account the objectives of the Seminar and the ideas, suggestions and recommendations put forward by participants and lecturers during group and plenary discussions.

I. Mental retardation in the Caribbean region

(1) As in other regions of the world, it is estimated that one half of 1 per cent of the population in the Caribbean region is moderately and severely retarded. Rehabilitation and care services are at the pilot development stage in some countries and non-existent in others. The main problems hindering or preventing the full development of such services are as follows:

- lack of basic information on the nature of the problem;
- lack of manpower;
- lack of training capability;
- lack of relevant models;
- low priority accorded by governments to rehabilitation programmes;
- limited budgetary resources;
- negative attitudes and lack of appreciation on the part of the general public of the needs and potentials of the retarded.

(2) The Caribbean Institute on Mental Retardation and Development Disabilities, which is the technical arm of the Caribbean Association for Mental Retardation, is leading the way in attempting to overcome these problems and has identified major priority areas including the changing of public attitudes through a carefully planned public education programme, the identification and dissemination of appropriate models and technologies and the greater utilisation of parents as partners.

II. The rights of the mentally retarded

(3) The world community has recognised the rights of mentally retarded people to an independent existence and to services which will enable them to achieve this goal. (United Nations Declaration on the Rights of Mentally Retarded Persons.) In so far as vocational rehabilitation and employment of the
mentally retarded are concerned, the Declaration states that "The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities".

III. The principle of normalisation

(4) This principle should be embodied in all rehabilitation activity in the field of mental retardation. This means that the mentally retarded should be placed on an equal footing with other human beings in all aspects of daily life, including civil rights, i.e. the right to be properly housed, the right to education and work. In the planning of educational and vocational services for the mentally retarded, the normalisation principle calls for:

- the admission of mentally retarded children to normal classes or to special classes in normal schools;
- the admission to general community vocational training facilities for all who can benefit;
- the integration in the general working community of those who have the capacity, after training, to enter competitive employment.

(5) The obstacles to full normalisation include:

- non-acceptance of the retarded by their parents;
- overprotection of the retarded by parents, professionals and others;
- peer group pressures;
- low priority accorded by governments to services for the retarded and to prevention of retardation;
- institutionalisation.

(6) Efforts to achieve normalisation of the retarded in the Caribbean region have been mainly confined to early stimulation, integrated education and a few modest workshop programmes for the retarded. Much more needs to be done to ensure "normalisation" in the vocational training and employment fields.

(7) Each country in the region should support the efforts of the Caribbean Institute on Mental Retardation and Developmental Disabilities to implement the "normalisation" policy. In this connection, special efforts and programmes should be developed to mark the International Year of the Child (1979) and the United Nations International Year for Disabled Persons (1981).
IV. Rehabilitation goal for the retarded

(8) Before any assessment of competence or ability of the retarded is made, it is necessary to define the rehabilitation goal. The highest goal for the mentally retarded person is the same as that for any other person, i.e. a person who is totally independent, who is able to earn his or her own living, support himself and perhaps a family in his or her own community and have a happy, productive and respected place in society.

(9) The skills required by a retarded person to reach this goal through training and experience are as follows:

- Vocational skills (ability to do a job and earn a living);
- Independence (social and self-help skills relating to all activities of daily living);
- Behavioural skills (ability to get on with workmates, people in the community and family, and to conform to accepted standards of behaviour);
- Communication (ability to communicate with others both in understanding what is said and being able to respond);
- Mobility (ability to move around in the community);
- Literacy (where possible).

V. Pre-vocational preparation of the retarded

(10) Pre-vocational preparation should be started at the earliest possible stage of all education and training programmes for the mentally retarded. It should include training in activities of daily living, inter-personal relationships, behavioural and self-help skills. Although pre-vocational preparation has often to be planned on an individual basis, it should be remembered that the establishing of peer groups applying the principles of group dynamics often achieves the best results.

(11) All pre-vocational preparation programmes should include regular periods of physical exercises, group games and sports and outings. The majority of mentally retarded persons on entry to a rehabilitation programme are often in very poor physical condition. Physical training and group sport help to improve muscle tone and better co-ordination of hand and eye, essential requirements for vocational training and employment.

(12) Parents and parent groups should be regularly consulted in the pre-vocational preparation of their retarded children. Employers too should be encouraged to assist in the pre-vocational preparation process by offering trial employment to the retarded.
In summary, a pre-vocational preparation programme for the mentally retarded should include:

- training in basic skills of daily living;
- opportunities for socialisation;
- physical reconditioning;
- group and individual counselling;
- real life experiences involving contact with the world of work;
- simulated job experiences to develop technical skills and experience of working with others;
- development of desirable attitudes to work, good work habits and stability necessary to hold a job;
- provision for suitable reception of the retarded by co-workers, employers and trade unions.

VI. Task analysis as a means of training the retarded for work

The employment capacity of the mentally retarded has been grossly underestimated. Using the "Task Analysis" method on a group or individual basis even the severely retarded can be taught quite complex tasks.

A written or illustrated Task Analysis which describes how the task in hand can be broken down into its basic constituents is in effect a step-by-step teaching plan. It allows for the task to be taught in the right sequence so that the whole job from start to finish can be tried at each attempt. It alerts the instructor to potential areas of difficulty and facilitates the plotting of a learner's response to training.

In applying the Task Analysis technique, care should be taken to ensure that each operation is carried out correctly and in the right sequence. Accuracy rather than speed is essential, and learning should be spaced out (i.e. three separate 20-minute periods rather than a one-hour session).

Verbal encouragement and support are essential. The trainee's errors must be pointed out and he should be given an opportunity to correct his own mistakes. If the trainee has difficulty in understanding verbal instructions, the required movement or sequence can be demonstrated with the instructor guiding the learner's hand in carrying out the necessary movements.

The principle of "over-learning" should be applied, with the learning process taken well beyond the first correct task performance. The learning process thus becomes deeply engrained.
The trainee should be given an opportunity to pass on his acquired knowledge to others. This acts as a great stimulus, for the opportunity to teach is very much appreciated by the mentally retarded.

**VII. Training of personnel**

The size of the mental retardation problem, coupled with the lack of trained staff in the Caribbean region, makes it imperative to identify and develop a pool of local skills, knowledge, resources, materials and information to be made available to government and non-government organisations in the Caribbean region. The Caribbean Institute on Mental Retardation and Developmental Disabilities, on behalf of the Caribbean Association for Mental Retardation, is the organisation in the region best equipped to carry out this task. In this connection it should be given all possible help and encouragement by governments of the region, international governmental (United Nations, ILO, WHO, UNICEF, UNESCO), and national and international voluntary organisations (particularly the International League of Societies for the Mentally Handicapped, Rehabilitation International and Goodwill Industries).

Not only is there a need to recruit additional personnel, but existing staff also require additional or refresher course training to bring their knowledge up to date. Short-term (3-day, 7-day, 2-week) training courses, workshops, seminars, in-service training should therefore be organised on a regular and continuing basis covering such subjects as organisational skills (leadership), behavioural management skills, early stimulation of the retarded, basic philosophy of rehabilitating the mentally retarded. With regard to vocational rehabilitation, staff training should be related to specific subjects such as workshop management, counselling placement, task analysis, the vocational needs and potential of the retarded, etc.

**VIII. The role of volunteers**

Voluntary organisations and individual volunteers will always have a vital role to play in rehabilitation programmes for the mentally retarded. In particular, they can provide direct services or assistance (for eventual take-over by government) to the retarded. They can also act as pressure groups, monitoring services, encouraging society in general, local, national and international authorities, etc., through public information and education programmes, to recognise the basic human rights of the mentally retarded person and to provide badly needed services (e.g. it was the International League of Societies for the Mentally Handicapped which sponsored, drafted and pressed for the adoption of the UN Declaration on the Rights of Mentally Retarded Persons).

In both rural and urban areas voluntary bodies and volunteers can assist in identifying and screening those retarded who need help. They can also assist in organising transport for
the retarded to enable them to benefit from available services; they can act as teacher aides, help to organise summer camps, sport and leisure activities for the retarded, organise fund-raising campaigns, toy and book libraries and provide a follow-up service following rehabilitation and placement. Good motivation, a deep interest for the well-being of the retarded and an understanding of their needs and potential are the main attributes required of volunteers.

IX. Widening employment opportunities for the retarded

(24) As stated above, the mentally retarded, even the most severe cases, are capable (with proper preparation and training) of undertaking a wide range of unskilled and semi-skilled work both in urban and rural areas.

(25) The group approach to employing the severely retarded in an "enclave" setting has been successfully developed in many countries, e.g.:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picking fruit and vegetables</td>
<td>Israel</td>
</tr>
<tr>
<td></td>
<td>USA</td>
</tr>
<tr>
<td>Forestry work</td>
<td>Scandinavian countries</td>
</tr>
<tr>
<td>(planting seedlings)</td>
<td></td>
</tr>
<tr>
<td>Salvage work</td>
<td>Canada</td>
</tr>
<tr>
<td>(recovering cardboard and glass for reprocessing)</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Packaging (medical supplies)</td>
<td></td>
</tr>
<tr>
<td>Bottling of fruit and vegetables</td>
<td></td>
</tr>
<tr>
<td>Parks and garden maintenance</td>
<td>United Kingdom</td>
</tr>
<tr>
<td></td>
<td>USA</td>
</tr>
<tr>
<td>Assembly of motor-car parts</td>
<td>Poland</td>
</tr>
<tr>
<td>Greenhouse flower growing</td>
<td>USA</td>
</tr>
</tbody>
</table>

(26) As most countries in the Caribbean region have high rates of unemployment, it is difficult at the present time to find jobs in the open labour market for the trained mentally retarded. It is important therefore to think in terms of "job creation" for the retarded. In this connection and in addition to the "enclave" approach, the development of co-operatives of the disabled, including the retarded (as in Poland where 200,000 disabled persons including the mentally retarded are successfully and profitably employed in a very wide range of industrial activity) is recommended.

(27) As with other disability groups, it is unrealistic and impracticable to draw up a list of jobs which the mentally retarded can perform successfully - the range is far too wide for this. However, the following types of work, by no means exhaustive, are considered to offer or have offered suitable employment outlets for the retarded:
Janitorial and housekeeping  Garage  Poultry and rabbit raising  Laundry  Fishing  Hotel and catering  Boat building  General services (municipal)  Silkscreen printing  Office and shop work  Garment making  Messenger  Vegetable growing  General labouring/handyman  Sugar industry  Furniture making  Citiculture  Packaging  Banana growing  Newspaper delivery  Car washing  Ceramic  Wood, metal and leather work  Electronics

(28) Other means of widening employment opportunities for the mentally retarded which should be considered by governments include the reservation of specific jobs which the retarded can undertake successfully (e.g. car park and lift attendant, messenger); setting a lead to the private sector by employing a quota of disabled persons including the retarded, admitting retarded persons to existing training courses and employment schemes for the general population (e.g. community development projects, co-operatives); providing production work to workshops employing the mentally retarded; subventing the work projects of voluntary organisations concerned with the retarded.

X. Shielded work for the retarded

(29) It is recognised that the sheltered workshop offers a traditional employment outlet for the mentally retarded either on an integrated (i.e. with other disability groups) or segregated basis. Indeed, in many countries with high unemployment, it may offer the only employment outlet for them.

(30) In recent years there has been much rethinking on the role and function of sheltered workshops, particularly since it is often difficult to subsidise the trading losses which many workshops experience. Because of the latter, the title "Sheltered Workshop" has become associated with losses, need for subsidy and provision of work for marginally productive people.

One should therefore look at the many options that might be available for employing the retarded which do not require the construction of buildings but offer work in other settings (e.g. other industries, firms, offices, agriculture, etc.). The centre or office which organises and develops such work opportunities could be called an Employment Development Centre.

Where workshops are established they should be operated on business and production lines even if they do not make money. Titles of such workshops should indicate that industry is involved and should not suggest charity or indicate that the workers are handicapped.
(31) Production work to be undertaken in a workshop for the retarded should be obtained from the public and private sectors with government taking a sponsoring lead in offering contracts or subcontracts. Such work might include the making of uniforms, bed linen, flags, resilvering of cutlery and mirrors, cardboard box making, soap wrapping, assembly of electrical components, crate making and repairing, concrete block making, etc. In urban and rural areas, groups of retarded workers could maintain buildings, service gardens, work in forests, orchards, etc.

(32) Prior to the selection of production work on the workshop's own account (i.e. as distinct from subcontract work) a careful market survey should be undertaken to ensure that there is a ready sale for the goods produced.

(33) The need for a sound administration and skilled management of workshops cannot be overemphasised. Whilst voluntary organisations will frequently have a major role to play in establishing and developing workshops for the retarded, it is government which must ultimately assume financial responsibility for a national workshop programme for the disabled, including the retarded, either directly or through the agency of a voluntary organisation.

(34) Governments can also assist workshops for the retarded with the following supportive measures:

- tax exemptions for the allowances of trainees and raw materials used;
- ensuring that workers are covered by the compensation laws in case of accident;
- a grants system to cover operating losses.

XI. Regional and international assistance

(35) It is strongly recommended that governments of the Caribbean should support and utilise to the full the services of the Caribbean Institute on Mental Retardation and Developmental Disabilities in its work of programme planning, guiding, training, and conducting research into problems associated with the rehabilitation of the mentally retarded.

The Institute should be supported and encouraged in efforts to develop models for employment and other vocational services for the retarded, early stimulation programmes and capability for training rehabilitation staff.

Similarly the efforts of the Caribbean Association on Mental Retardation to build up the organisational capability of the national organisations for the retarded in the region should also be supported.

(36) It is further recommended that government should give higher priority to programmes of vocational rehabilitation for the mentally retarded. (In several of the countries represented such services are non-existent.)
The United Nations and its specialised agencies (ILO, WHO and UNESCO) are urged to provide much-needed and co-ordinated support to countries in the Caribbean region for the development of vocational rehabilitation services for the mentally retarded. In particular, the ILO is requested to continue its Caribbean Regional Vocational Rehabilitation Adviser service.

Continuing support for programmes of rehabilitation of the mentally retarded in the Caribbean region from the Danish and Canadian International Development Agencies, the US Agency for International Development, the International League of Societies for the Mentally Handicapped, Rehabilitation International, Goodwill Industries, the US President's Committee on Mental Retardation and other organisations would be very much appreciated.
CHAPTER 4

A selection of lecture and country papers presented at the Seminar

(a) Lecture papers

1. Mental retardation in the Caribbean: problems and solutions

by

Dr. Marigold J. Thorburn

In this paper I would like to present:

(1) A brief background history of developments in the mental retardation field in the Caribbean.

(2) A summary of the present status of services, training and research.

(3) Some major problem areas and issues.

(4) Suggestions for some solutions and strategies.

1. Historical background

I will be dealing mainly with the territories of the Caribbean who have a recent colonial past. I do not profess any knowledge of the larger South American countries and therefore apologise for omitting reference to them.

There are four language groupings and all the islands have a fairly recent colonial history except for Haiti and Cuba.

The Caribbean countries first got together to discuss the topic of mental retardation (MR) in 1970. Prior to that time, there were services for the MR in only seven countries - Trinidad and Tobago, Dominican Republic, Barbados, Jamaica, Puerto Rico, the Bahamas and Cuba. In most of these, with the exception of Cuba and Puerto Rico, the services were privately run by voluntary agencies. Thus these countries followed the pattern seen in other part of the world of voluntary or church organisations pioneering this field. In some countries the services were linked with and assisted very largely by religious orders - notably in Barbados and Trinidad. Puerto Rico and Cuba have achieved the greatest level of advancement due no doubt to the heavy investment in all types of human service programmes by their affiliation with major world powers. As such, their situation has been the exception rather than the rule.

Any advantages or benefits bestowed by previous colonial masters of most of the Caribbean territories, however, did not include services or expertise in dealing with the handicapped. One of the major problems faced by the countries of the region is the low priority assigned to this field.
The pattern of services available in 1970 in Trinidad, Dominican Republic, Barbados, Jamaica and the Bahamas was basically small segregated school programmes run by voluntary agencies with variable subsidies from government. I think it is true to say that, with the exception of the Netherlands Antilles and Suriname, none of the other territories had services at all. What did exist in many countries was a mental health association.

One of the major goals of the newly formed Caribbean Association on Mental Retardation (CAMR) in 1970 was to stimulate the development of national voluntary associations for the MR in all the other countries of the region.

This has largely been achieved because between 1970 and 1977 all the countries, except for St. Kitts and Montserrat, have formed such an association, which in many instances had to break away from the existing mental health association. This period has also seen the development of small schools in each one of these territories.

So the pattern of development has paralleled economic development. Puerto Rico and Cuba have gone ahead and followed patterns of their respective "sponsors" while the so-called LDC's have enlarged and expanded and in varying degrees, usually by extending their educational programmes to a wider population and by expanding vertically to develop sheltered workshops. Jamaica and the Dominican Republic have also developed early stimulation projects. The LDC's have only just begun to enlarge and develop further. A major problem affecting development has been the lack until recently of government involvement.

In 1974, at the third congress of the CAMR, the idea of an institute was proposed by Dr. G. Allan Roeher, then Director of the National Institute on Mental Retardation of Canada. The CAMR accepted this idea and by the end of 1975 a grant was solicited from CIDA to commence this project. I would like to think that the Institute has played a role in the development of services and training in the last two-and-a-half years and I hope to have the opportunity to expand on this later on during the Seminar.

2. Present status of services, training and research

Services

Table I shows in summary form the present approximate status of service provisions under various headings according to the most recent information we have in each of the countries listed.

Training

Training programmes specifically for preparing personnel for MR services are even more sparse. Teacher training in special education is provided at the University of Puerto Rico, the Dominican Republic and at Mico Teacher Training College. It is shortly to commence at Erdiston College in Barbados, and the Trinidad Government is also planning for this new venture. Vocational rehabilitation training is offered in Puerto Rico; I am
not aware of the Cuban facilities. The Allied Health Training Programme provides a one-year course for occupational therapy assistants. Some of these have been utilised in institutions in the region.

Short-term training for specific groups of child development aides for early stimulation in Jamaica is provided from time to time according to need. Other than the short courses and workshops run by the CIMP and the various national organisations in the Caribbean, there are no other training programmes. CIMP has had input (insufficient so far) into on-going training at various regional institutions for doctors, nurses, public health nurses, social workers, physiotherapists, teachers and child-care workers. A summary of CIMP training activities is shown in table II.

Research

Major research relating to mental retardation has been sparse. There have been small studies done on evaluation and assessment tools for children, including the Bayley Scales of Infant Development, the ITPA, on the types and causes of handicaps seen in clinic populations (in the Dominican Republic and Jamaica), attitude studies, operational research on projects. This year, surveys of school children are being conducted in Jamaica and Trinidad, to be followed by community surveys of prevalence of handicaps. During the last two years, as a result of the orientation workshops that have been conducted by CIMP, students in different training courses have chosen aspects of BR for their topic of study for thesis and dissertations. However, our knowledge is sparse. CIMP has identified the areas shown in the accompanying table III as priority areas for research study.

3. Problems and issues

From the foregoing description, it can be seen that, historically, patterns of development in the Caribbean have repeated evolutionary patterns of the more developed countries. The question is then "Do we need to do anything to change that pattern?" and, if so, "Have we the will and the means to change it?"

I think the answer to both of these questions is yes. But, before I explain why, I would like to delineate some of the problems we face in the region.

These can be summarised simply as:

(1) lack of basic information on the nature of the problem;
(2) lack of manpower;
(3) lack of training capability;
(4) lack of relevant models.

These four problem areas are responsible for lack of services. But they are due primarily to the pervasive attitude in all sectors of the society towards the justification for the need for providing services for the mentally retarded.
I would now like to go into more depth into some of the attitudinal problems and then say a few words about the four areas of deficiencies mentioned above.

**Negative attitudes**

Throughout the world, attitudes towards the MR have been negative. Many times in the Caribbean, I have commenced workshops and training courses by eliciting from the participants attitudes prevalent in their society. The Caribbean societies regard the handicapped and particularly the mentally retarded as a burden, also with shame, fear, pity and ridicule: fear because of fear of the unknown and the unpredictable, or perhaps that the handicap is infectious; a burden because they are regarded as worthless, useless and dependent; shame because of ignorance of the cause and that it might be due to some fault of their own or a punishment for a sin possibly committed in the past; pity because of their supposed helplessness and need for care and protection; ridicule because of embarrassment at their behaviour, and a wish to dissociate themselves from responsibility.

These attitudes prevent parents from bringing their children forward for assistance even when services are offered sometimes. In one island in the one small school, all the children are over 12 and there is no waiting list! In Barbados and Jamaica, where attitudes are more favourable, there are long waiting lists for services. Parents request placement of their children either because they are a burden to the family or because they genuinely believe that a residential home can take better care, but this request is made when the problem has become intensified and unbearable. They often either underestimate and overprotect or overestimate and become frustrated.

**Teachers**

Teachers are faced with children with mental retardation in the regular schools, since the problem is often not recognised in the mildly retarded. They are not equipped either in attitudes or in techniques to properly identify or manage these children. Classes are large and therefore the child is either pushed to the back of the class and ignored or perhaps is given undue attention because of "bad" behaviour, and thus a behaviour problem develops and becomes reinforced.

Professional staff underestimate the mentally retarded and highlight the failures and the problems. Of course, the failures and the problems may constitute the bulk of those seeking assistance, as the well-adjusted and fully occupied mentally retarded person or employed person will already have been successful in obtaining placement somewhere and so does not come forward for assistance.

The medical profession has probably been one of the most negative and at the same time most influential in its views. Its supposed superior knowledge of the nature of MR and its negative attitudes towards the outcomes have confirmed the general attitude of regarding the MR person as a useless individual and not worth investing time and effort in. This is conveyed to parents at
diagnosis by reluctance to inform the parents and the suggestion of a hopeless prognosis. In fact, lack of knowledge of new techniques and approaches has misled many a parent. Fortunately, the newer generations of doctors, and paediatricians in particular, are beginning to be more positive and better informed. Quite often this comes about as a result of consumer demand.

Employers also share these attitudes and are not willing to give a chance to someone even with the necessary skills for a job. They may say, "Well, I'll take someone with a physical handicap or who is deaf or even blind but not the mentally retarded", or they may say, "Well, I'd love to take a handicapped person but I just don't have any vacancies right now".

Government policy usually reflects the pressure and the attitudes of the people. In Jamaica the Government has shown more progressive attitudes in this respect than in most of the Caribbean territory up to now. Usually the government response to pressure groups for funding services has been, "Oh, we can't afford it at present", which means that they do not want to waste money on this particular effort. It is low priority. "We must have regular education" - (as far as health is concerned, malnutrition, infectious diseases, etc.) "properly taken care of first" - neglecting to realise that one of the reasons that education is of poor quality is because teachers are bogged down by having to teach disabled as well as normal children in their classes and using inadequate techniques and approaches. Finally, the international agencies, both governmental and non-governmental, reflect the priorities of government and, with the notable exception of the ILO, have only recently indicated a preparedness to assist projects for the handicapped.

What is the answer to this problem of negative attitudes?

One answer is to try and diminish the behavioural characteristics of the mentally retarded that lead to negative attitudes. It is, after all, what we see that tends to reinforce pre-existing attitudes! How often have I heard people say, "Oh, is that boy (or girl) retarded? He doesn't look it". As if all MR people have a characteristic appearance.

Another is to recognise, explore, clarify and educate people to expose the favourable characteristics to give visibility to the problem and demonstrate a willingness to solve it.

I believe that the more enlightened attitudes seen in Barbados and Jamaica are probably the result of frequently hearing about new programmes or projects. Someone remarked in St. Vincent that nearly every week they learn of some new project in Jamaica or Barbados. People realise then that someone considers it worth while tackling the problem. This can go a long way towards dealing with the general negative attitudes.

Our New Trends Workshops served as a forum for hearing and rationalising attitudes and hopefully changing them. However, much more needs to be done and I hope to be able to persuade the CIBM to adopt public education as our International Year of the Child project.
Other problems identified and solutions

Clearly lack of materials, information and manpower can be tackled with appropriate investment of time, effort and money. The question of appropriate models, however, is a key issue. I would like to focus now on two main issues, one is the medical aspect, which is not yet in my opinion being sufficiently challenged, and the other is what is sometimes known as appropriate technology.

Medical aspects

In the Caribbean, the associations for the mentally retarded have attended to concern themselves largely with the rehabilitation of the handicapped. Lip service is paid to the need for prevention. The President's Committee on Mental Retardation two years ago set as one of its goals the reduction of the prevalence of mental retardation by 50 per cent by the end of the century. This was felt to be a realistic goal.

However, one internationally known expert does not agree with this. He feels that to expect the investment of the necessary money and manpower is unrealistic. Our own data here indicate that at least 50 per cent of moderate and severe mental retardation is preventable. Cost beneficially, it can be shown that preventive measures such as raising standards of ante-natal and newborn care and improving immunisation coverage are highly cost-beneficial as compared with providing services for affected persons.

Rubella immunisation also falls in this category, only perhaps it is not quite so highly cost-effective as the others previously mentioned.

We need to pay more attention to preventive measures both through public education media and through advocating inputs into the health services to improve skills and means of dealing with children which will help to prevent the development of handicapping conditions.

Appropriate technology

Appropriate models of services, educational strategies, appliances and products for the handicapped are sparse.

PAH published a book in 1975 called "Health by the People". This describes nine health projects in developing countries in which more appropriate and cost-beneficial approaches have been developed to meet health needs and health problems. There is a great need for this approach in the rehabilitation field. At the time when I came across this book I found it in the Portage Project of Wisconsin. By adapting this project and combining it with another model - the Community Health Aide - we were able to pioneer what I hope will be considered a cost-effective approach to providing early stimulation for pre-school handicapped children.

Other appropriate models and technologies include the Canadian manpower model, task analysis, the precision teaching approach and some applications of behaviour modification.
Finally, in the vocational area, we need to take a keen businesslike approach to the development of workshops and what workshops produce. Are we just going to set up business enterprises where the handicapped person produces something useful and needed in society? It needs to be his work too. As Mrs. Mary Charles said when I visited her in St. Lucia, "We don't bother to make anything that is not 75 per cent the work of the clients. If the instructor has to do more than 25 per cent there is no point".

I believe that there are places in the developing world where people have developed low-cost rehabilitation strategies. The Partners of the Americas Programme is at the moment investigating a possibility of getting together material which might form the basis of a document which might be called "Rehabilitation by the People".

Conclusion

From the above discussion it should be clear that two major priority areas of activity should be the changing of public attitudes by a carefully planned public education programme and the identification and dissemination of appropriate models and technologies. From these two we should proceed to deal with the three other problem areas that I mentioned earlier:

(1) lack of information of the nature of the problems;
(2) lack of manpower;
(3) lack of training capability.

These three are all very closely related to each other since of course (2) is contingent on (1) and (3).

We therefore now need an analysis not only of the kinds and levels of handicaps in the community (a head count) but four other very important pieces of information:

(1) What are the causes, so that we can help develop specific prevention strategies?
(2) What are the needs of the impaired person in his or her community setting?
(3) What are the services and detailed tasks required to help those impaired persons achieve as normal and as integrated an existence as possible?
(4) What kinds of people and what kinds of training do these people need to carry out these tasks?

In the meantime, we can take a problem-orientated approach of providing services as the problem and needs present themselves. This helps to answer the immediate need, but in the long run it really only serves to uncover other problems that are not planned.

In fact, comprehensive planning needs to be undertaken on a firm information and data base. This we have not yet done, but it must be done while we are still in a developing stage before we reach the chaotic and fragmented situation which exists in many more
advanced countries where everything is added on piecemeal, new committees and new councils are set up to solve co-ordination problems, and new cost-effective strategies are resisted because they threaten or challenge existing institutions.

Earlier I asked the question: "Do we need to do anything about changing patterns of development?" The answer must be yes. Our needs now are different and can be met in different and more cost-effective ways than have been done in the past. So once again I make a plea for comprehensive rehabilitation planning before we start jumping into expensive and traditional approaches.

"Have we the means to change the pattern?", again, I believe we have.

"Do we have the will?"

That is the 6 million dollar question.
### Table I: Programmes for the mentally retarded in the Caribbean

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>E.S.</th>
<th>Special education</th>
<th>Adult programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antigua</td>
<td>70 200</td>
<td>-</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Aruba</td>
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<td>-</td>
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<td>36</td>
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<td>Barbados</td>
<td>250 000</td>
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<td>Belize</td>
<td>150 000</td>
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<td>-</td>
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<td>British Virgin Isl.</td>
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<td>14</td>
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<td>117 800</td>
<td>-</td>
<td>60</td>
<td>-</td>
</tr>
<tr>
<td>St. Vincent</td>
<td>100 700</td>
<td>-</td>
<td>30</td>
<td>-</td>
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<td>Suriname</td>
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</tr>
<tr>
<td>Trinidad</td>
<td>1 200 000</td>
<td>-</td>
<td>66</td>
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**Note:** St. Kitts and Montserrat have no programmes for the mentally retarded.
I do not have accurate information on Cuba or Puerto Rico.
* Government gives financial support to voluntary agency.

**Abbreviations:**

E.S. - Early stimulation  
Vol. - Voluntary association  
Segreg. - Segregated  
Integ. - Integrated  
A and G - Assessment and guidance  
Prevoc. - Vocational training  
W/shop - Workshops  
SPO - Selective placement officer
<table>
<thead>
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<th>Date</th>
<th>Topics and type of course</th>
<th>Place</th>
<th>No. of days</th>
<th>No. of persons</th>
<th>Level of persons</th>
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<td>Applied behaviour analysis (local)</td>
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<td>10</td>
<td>40</td>
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<tr>
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<td>Jamaica</td>
<td>10</td>
<td>45</td>
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<tr>
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<td>7 1/2</td>
<td>55</td>
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<td>20</td>
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(1) Role of government and voluntary agencies  
(2) Legislation  
(3) Orientation course for students
Table III: Caribbean Institute on Mental Retardation and Developmental Disabilities

Priority areas for research

The following areas are those which have been identified as high priority for research in the field of mental retardation, in which the Institute would be greatly interested. Most of these areas are prerequisite for the planning of services and training in this field.

I. Prevalence of MR problems in the community in persons of all ages using behavioural indices. A design for such a study needs to be formulated as well as implemented on a regional basis.

II. Prevalence of behavioural and learning problems in basic and primary schools.

III. Attitudes of parents to their children, with a sub-study on attitudes of fathers to their MR children.

IV. Attitudes of the community at large to mentally retarded persons in the population.

V. Attitudes of different sectors of the population, especially employers, trade unions, teachers and later perhaps the police.

VI. Research into the use of mass media in rehabilitation and public education. Here again a strategy needs to be developed for providing rehabilitation education.

VII. Standardisation of screening instruments at pre-school, school and vocational levels for the purpose of decision making on placement of developmentally disabled children in different settings.

VIII. Alternative approaches to rehabilitation of the mentally retarded for use especially in distant or isolated rural and sparsely populated areas. This would include the study of areas where handicapping conditions are known to be prevalent, probably as a result of intermarriage.
2. The concept of normalisation in mental retardation

by

Mr. N.E. Bank-Mikkelsen

Throughout the ages handicapped people have been regarded as persons who did not belong to society. Handicapped people were for centuries segregated from the general community.

This segregation resulted as a rule in poorer treatment of the handicapped than of the rest of the population. It is a generally accepted fact that group segregation is equal to discrimination.

Mentally retarded form such a group, a group which, although difficult to define, could easily be segregated, as they have common group characteristics. Until the nineteenth century no distinction was made between mentally ill and mentally retarded persons. It was not until the middle of the nineteenth century that attempts were made to separate these two groups. The belief in treatment and cure of mental retardation, then defined as a special medical problem, curable through treatment, experienced rather short-lived optimism. The cure which was expected did not occur and the result was negative attitudes towards the mentally retarded citizens and mental retardation as such. One did not believe in treatment of mental retardation, either through medical or educational methods. The humane attitude towards these "poor" citizens then resulted in mere nursing and care. That is why large, often remotely placed, institutions were built where the mentally retarded were hidden away. Such huge institutions with 1,000 or more beds merely underlined the view that mental retardation was a permanent condition, not one to be improved through treatment. As mentally retarded people were labelled "useless" citizens, there seemed to be no special reason to treat them well; they merely should be kept alive.

It was usual then to protect the retarded against the society in which they had to live. Until the middle of this century this protective attitude marked all activities in the field of mental retardation.

Even until recent times, psychiatric circles considered some of the mentally retarded as dangerous or potential criminals with an innate tendency to vagabondage. This theory strengthened the protective concept in two ways: on the one hand to protect the mentally retarded against society and, on the other, to protect society against the mentally retarded.

This twofold protective attitude towards the mentally retarded was in line with the generally prevailing negative attitudes of society towards any people who deviate from society's norms; such deviations include race, religion, physical or mental conditions.

Manifestations of these attitudes and the resulting policies take the form of the above-mentioned huge institutions or ghettos found all over the world; most of these institutions are marked by hopelessness, overcrowding and understaffed conditions - generally poor standards.

The assumption behind this treatment of the mentally retarded has proved to be wrong. New knowledge, improved financial and
technical possibilities have resulted in improved attitudes towards handicapped people, in this case the mentally retarded and a new internationally accepted treatment policy.

Possibly all kinds of mental retardation could be subject to treatment in the broadest sense of the word. Mental retardation is not a permanent, life-long condition, but dynamic in its nature, which means susceptible to improvement.

Without regard to the degree and category of mental retardation it is possible through treatment, training and education to develop a mentally retarded person. In principle, mentally retarded persons can be developed to the same degree as other persons, namely to the optimum of their capacity. In practice, there will be great differences as to how far development can be reached, but all human beings have possibilities for development, and a right to have these possibilities realised.

We know today that early stimulation is of vital importance. Early identification and the earliest possible initiation of treatment are therefore absolutely essential.

In addition to his new knowledge, and this too has been of the utmost importance, the relatives of the mentally retarded, who in many countries have formed organisations of their own, demand that the mentally handicapped persons' civil and human rights be guaranteed. Any of us can have a mentally retarded child, no matter what our financial or social position is. In years gone by the superstitious belief that a mentally retarded child was a retribution of one's sins is now known to be completely unfounded. Parents of mentally retarded children should therefore never feel guilty or ashamed. The mentally retarded individual is just as valuable as the so-called normal individual. Negative discrimination and segregation are now giving way to equal legal status for these citizens. We are moving from "charity to rights", as the International League puts it. The object in view now is to offer the mentally retarded an existence as near as possible to a normal existence. This is what for a number of years has been the objective as regards the improvement of services for the mentally retarded in the Scandinavian countries, where we call it the normalisation principle.

The main concepts behind this principle are that the mentally retarded are a natural element of any population. Some mentally retarded persons are minus variants of the general mental distribution. Some are pathological deviants, others again are mentally retarded as a result of the social and environmental conditions in which they have to live.

Consequently, mentally retarded persons are no special group, which can or should be segregated, but members of society, born with the same right to live and with the same right to treatment as all other citizens.

The normalisation principle does not by itself stand for anything other than the idea that the handicapped - in the present
The mentally retarded - should have the same rights and obligations as other citizens. That the normalisation principle has proved to be comparatively revolutionary with positive consequences to the mentally retarded is bound up with its contrast to the "anything but normal conditions" formerly offered to the mentally handicapped. Normalisation does not aim at making the mentally retarded into so-called normal people. For one thing, there is no description of "normalcy"; moreover, it has to be realised that the mentally retarded are defined as a group of persons who, in several respects, are not what we will call normal. What the goal is, is not "normality", but "normalisation". Normalisation means acceptance of the mentally retarded with their handicap, and offering them normal living conditions, i.e. offering them the same conditions as are offered to other citizens, inclusive of treatment, education and training adjusted to the handicapped person's individual need to enable him to develop optimally. Normalisation is not a new "ism" - it is more of an anti-dogma indicating that we do not need special theories for the mentally retarded, but equality in the sense we use it here.

What is "normal"?

The interpretation depends on the conditions in the country concerned; it is dependent on the social, cultural and religious conditions existing at any time. Any detailed description of normalisation must distinguish between general conditions of life, and treatment in its widest sense.

Conditions of life must be viewed in the three dimensions: housing conditions, working conditions and leisure-time activities. Furthermore, we must distinguish between children and adults.

As regards housing conditions: in most countries it is considered normal for children to live with their parents. That this is generally the best thing for the child, too, is here taken for granted.

Mentally retarded children, therefore, ought to live with their parents, wherever this is feasible. There are mentally retarded children whose state is such that they cannot live at home. There are homes which are unable to offer the mentally handicapped acceptable living conditions. In such cases the mentally retarded must be invited to live outside their homes in institutions and homes established to meet these needs. The principle is thus entirely unlike the institutionalisation principle, under which the mentally retarded were removed from their natural homes and isolated in generally large, remote, inhumane institutions with such consequences as severed connections between parents and children to the detriment of both parties, and an existence in dehumanised institutionalisation. Where a child in the said situation cannot live at home, he must be asked to live in an institution, but this ought to be a small facility, i.e. with a maximum of 12 children in the same house. If, for the reason of treatment, a larger group of clients must live in the same institution, then it is important that the different housing units are small. It must be the object of such small units to create a substitute home with a definite rhythm of everyday life, as in a private home. The clients should live in one place, go to work, to school or a kindergarten in another place (two-milieu-system).
All institutional routines of a collective character must be avoided. Bedrooms should be arranged as in private homes - large dormitories are at variance with the normalisation principle. Meals should be taken the same way as in a private family and life must, on the whole, be organised on a private-life pattern. This idea, in itself, is rather revolutionary in many countries, not because of the very principle, but in proportion to what has been done for decades.

It also means that boys and girls should live in the same place, as they do in private homes, and that relations between children and personnel should be warm and affectionate, personnel endeavouring to do what the parents would do, without, however, trying to compete with the parents, who have by no means renounced their right to their children. On the contrary they should visit their children as often as possible and have the children living with them during the holidays, weekends, etc., whenever this can be realised. It presupposes a close co-operation between the institution and the parents, and this again implies that the institution is near the parents' home ("nearness principle").

Where a child develops in such a way that he may return home, or where the treatment is completed, the child should, of course, return to his home; the basic principle is, as already stated, that the biological parental home is the best place for the child. Some countries attach so great importance to this point that public funds, if necessary, will grant financial aid to the parents in order to enable them to keep the child at home. In addition, child and parents are offered expert advice, e.g. visiting nurses, therapists, social workers, etc., who all make it their job to contribute to the child's well-being in his home.

In most countries it is customary for a child to move from his parental home on attaining adult age, whether the move be to his own house, a flat or a room. It is likewise right and proper for the mentally handicapped to move away from home when they reach adulthood, for the sake of the parents as well. Having a mentally retarded child is in itself a heavy strain, and it is not reasonable for parents to shoulder this duty longer than they do in the case of their other children. Moreover, the mentally retarded person's development will generally progress when he moves away from home, inasmuch as experience goes to show that parents are apt to adopt an exaggeratedly protective attitude towards their mentally retarded child, an attitude that will not promote the child's self-dependence, but may keep him constrained in an artificial child-to-parent relationship.

The mentally retarded person has now reached adulthood and must be treated as an adult, i.e. be accepted with an adult's characteristics, for instance, accepted also as a sexually developed adult. This latter problem is as a rule hedged with many rooted prejudices; prejudices that are apt to be intensified in the case of handicapped people's sexual life. It is not the intention here to enter into a detailed discussion on these problems, the elucidation of which would require a long account, but confine ourselves to point out the importance of taking a natural view of the sex-life of handicapped persons. They will generally be quite normally developed in this respect, and must be entitled to have a natural sex-life.
Mentally retarded persons who have lived at home in childhood will — because of their handicap — often be in need of help and support as far as their housing problems are concerned. Some can manage their separate household. The requirement will be for small homes: nursing homes, hostels, group homes and the like, where the mentally handicapped can live in small groups. Here, too, a number of about 20 to 24 in one place will be the maximum, seeing that the objective is to create a normal housing environment — and, at any rate, to prevent any institutional routine.

Experience, inter alia, in Denmark, proves that it is no more, and rather less, expensive to build and run small units than the large institutions of former times.

Housing conditions of mentally retarded persons should be no different from those of other people; any departure from this rule should be made only when special reasons prove it justifiable. The residence of physically handicapped persons, for instance, must be without stairs, and provided with corridors and doors that are wide enough for wheelchairs. Remember that most of the clients, living in institutions, are multiple handicapped.

Bedrooms should be arranged on the customary pattern for adults and for children. Young children who are living at home in the Scandinavian countries generally sleep together in one and the same room, for which reason our houses for the mentally retarded are provided with a maximum of four beds, even though there is a tendency nowadays towards separate bedrooms for children too.

It is, however, customary for adults to have separate bedrooms, so consequently modern housing for the mentally retarded is provided with private rooms which can conveniently be used as sitting rooms in daytime (bed-sitting room).

Now, turning to the second aspect of everyday life — work — we must once more distinguish between children and adults.

Work for a child means going to kindergarten (pre-school) and to school. Mentally retarded children should likewise be offered kindergarten, and they should be entitled to education.

The predominant element in a service system for the mentally retarded is education of the children. In this respect the mentally retarded have been neglected in many countries. The general compulsory education has been limited to those who could learn to read, write and do arithmetic. It appears that children who are mildly retarded are able to learn the three Rs, so this group has a clear right to education, but we know that all children can be taught, and it must be the duty of every country to extend an offer of teaching to all children, irrespective of their mental development. It must be considered a human right to have access to education. Backward children are more in need of education than any other group, and investment in education is invariably good economics. We have already demonstrated that an invitation to spend the day in a kindergarten or in a day-nursery is of pedagogical value to the children and a relief for parents who have their mentally retarded children at home. It is of importance that this pedagogical influence is brought to bear as early as possible.

In connection with the education of the mentally retarded there is no longer a basis for dividing them into trainable and educable — all children are educable.
Mentally retarded adults ought to have the same right to work and pay as other citizens. This often presupposes that they must be given preliminary vocational training, but many years' experience goes to prove that the mentally handicapped, even severely handicapped, can be trained to work in modern industries to the mutual enjoyment and benefit for themselves and their community.

That they should be paid in proportion to their performance would seem to be a foregone conclusion; many countries, however, have not lived up to this idea, but have exploited the mentally or otherwise handicapped.

As to those so poorly endowed by nature that they are unable to work, it must be the duty of the community to take care of them in a way commensurate with the normal standard of the community in question. This applies clearly to old mentally retarded people who must be offered conditions on a par with those of all other aged citizens in the country. These mentally retarded should also be activated. They must be offered some form of occupation if they cannot participate in productive work in sheltered workshops.

The third aspect in a normal existence consists of spare-time occupation and recreational activities. It must be a natural thing for the mentally retarded to have the same access to leisure hours and to participate in such recreational arrangements as the community extends to all other citizens. We mention this specifically because all countries have at all times failed to consider the mentally retarded as persons who had a right to activities during their leisure hours. Games and sport, holidays, travel at home and abroad, etc., were once considered a luxury as far as the handicapped were concerned. Nowadays it must be an established fact that the mentally retarded are entitled to the same benefits as other citizens.

As stated in the introductory remarks, the normalisation principle is essentially a corrective to the former negative discrimination of mentally handicapped as a body. The normalisation principle simply means that all citizens should have equal access to the same benefits. On this principle all problems as regards treatment of the mentally retarded can be solved. I have in the preceding exposition given a broad outline of the rights to housing, work (training and education) and leisure, and I now propose to give a brief account of the right to special treatment, which is also a consequence of the normalisation principle.

The mentally handicapped are essentially ordinary people with ordinary civil rights who happen to have a handicap; indeed, the majority of them are multihandicapped.

Mentally retarded people are not ill - they can be ill - they can have diseases also of psychiatric nature.

Modern health and social policy makes it a rule that all citizens are entitled to treatment for diseases and handicaps. In the more advanced countries this service is offered free of charge,
or it is part of a health insurance system where all citizens are
offered medical and hospital services on insurance basis and at a
price within the means of all concerned. This service may cover
treatment of common diseases or treatment by specialists. Mentally
retarded persons are often in need of specialist treatment, and it
is therefore in consequence of the normalisation principle that
mentally retarded persons should be offered specialist treatment.
This treatment may be of different types and in principle comprises
special education, which I have already mentioned.

Modern science has opened up new vistas for treatment methods,
and we may expect in the coming years to see a marked development of
these comparatively recent discoveries. Whereas developments
concerning housing, working and leisure conditions will consolidate
the similarity of existence in these respects of the handicapped
with that of other members of the community, we may look forward to
a great acceleration of developments in such spheres as special
treatment and special education techniques.

I should like to add briefly that normalisation means that the
mentally retarded should be placed on an equal footing with other
human beings - in every aspect of life, which also includes civil
rights. This means the right to housing, education and work. It
also means the right to vote, to marry, to produce children; the
right to sexual life, even if unmarried, and without producing
children.

Normalisation is the goal of our efforts. We may use
different methods to reach this goal. From former days we know that
segregation was a method which led clearly to the goal of those
days, namely to protect the mentally retarded in isolated
institutions and environments.

"Integration" is a method which may often lead to normalisation,
but integration is only a working method, not the purpose
itself.

Let me refer to the declaration, adopted by the United Nations
in December 1972 - The Declaration of the General and Special Rights
of the Mentally Retarded. It is a striking example of a fantastic
development in this area.

From being a forgotten minority, the mentally retarded citizen
has today changed to be subject of such a declaration.

The start was made at a Symposium on the Legal Rights of the
Mentally Retarded, arranged by the International League of Societies
in Jerusalem, a resolution was adopted at the Congress of the
International League, which four years later resulted in this UN
declaration. For those who know the international administrative
procedures the result must seem most remarkable.

You will see that the declaration contains the words "as close
as possible to normal life". These words were the basis for what we
call the "normalisation principle".
Finally, I should like to stress the importance of public relations activities. We must speak loudly about the conditions of life of the mentally retarded and their human rights. We must exploit every possible means of public communications to tell about the mentally retarded. We must open our institutions to criticism of the press, radio and television and we must, at the same time as we accept deserved criticism, speak about the many different possibilities that exist today, i.e. new attitudes, especially among the younger people and the sources of wealth at any rate in the industrial countries.

There are good reasons for optimism, although we must realise that there is still a great deal to be done in all parts of the world before everyone accepts all fellow human beings, no matter what their handicap.
3. Jamaica's vocational rehabilitation programmes for the disabled
by
Mr. A.N. Leslie

Kenneth Solly, in his pamphlet "The Different Baby", makes a very vivid point when he states that "every now and again among the apples on even the nicest tree, there is an unusual one, one with an altered shape, or color or texture ... taste it and it's certainly an apple, but one of nature's different ones".

Similarly every once in a while nature produces a "different" human being. Sometimes the difference is visible and physical like blindness, deafness and badly shaped limbs. At other times, persons are born who appear physically perfect, but whose mental powers will never develop like other people's.

These different human beings are or should be entitled to all the rights, privileges, dignities and respect which the normal person expects for himself in our society. Further, and most important, their handicaps should entitle them also to society's care without society's patronising attitudes. True concern for the handicapped should not exact the sacrifice of his self-respect and his human dignity.

It is true that in the Caribbean today there has been a marked improvement in the general public attitude to the handicapped. There is developing a greater public awareness of the causes of various handicapping conditions and also a greater public interest in the need to prevent the recurrence of some of those causes. Complementing these, there is greater public realisation that the community has duties and obligations to these persons.

This interest, understanding and realisation has in many cases been translated into positive and concrete action.

Here in Jamaica, as no doubt in the other Caribbean countries represented here today, our concern is not without economic significance, and on the other side of the coin we seek in our programme to maximise the output of the people we are here to discuss. When a man knows that he is contributing to his economic independence, and therefore his social independence, he feels like a man.

The search for this dignity and independence of the handicapped was left almost entirely in the hands of voluntary organisations until fairly recently. These organisations led the way in providing social services especially for the disabled. Public-spirited people joined hands in organising voluntary services for the blind, the deaf, the mentally retarded and so on. Other organisations such as the Mona Rehabilitation Centre, the churches and the Salvation Army were all great pioneers in providing services for the handicapped in Jamaica.

In 1973, the Government took a very positive step in providing services for the physically and mentally handicapped as it became more and more concerned with developing all its human resources. As an important aspect of this commitment, the National Vocational
Rehabilitation Service for the Handicapped was established by an administrative decision of the Cabinet which at the same time created the Jamaica Council for the Handicapped as an advisory body to the Minister of Social Security, and to assist him in the implementation of his programme for this group of persons.

In connection with the provision of that service a handicapped person is defined as an individual whose prospects of securing and retaining suitable employment is substantially reduced by a physical or mental impairment.

Vocational rehabilitation is regarded as a process of treating with the handicapped to achieve resettlement on a sound and economic basis.

In Jamaica, as in other countries, injury, disability and sickness cause loss of efficiency, employment and independence. When the full process of restoring the injured and the sick to normal working fitness is carried out, those losses are significantly reduced. It is important that vocational rehabilitation of the handicapped should provide the additional support, reduce or minimise unemployment, reduce inefficiency and loss of independence. The handicapped person's capacity is assessed, and he is encouraged to overcome the physical and personal problems which impede his resettlement.

He is given vocational guidance and good work habits and discipline are encouraged and fostered.

Not all handicapped persons require vocational training, however. Some are already skilled and others may not be suitable for or able to absorb training. A place must be found for all eventually.

With this background, then, Jamaica's Vocational Rehabilitation Programme was created with the able support of the ILO's technical programme. A working time frame was devised and the programme got under way in late 1973.

Current programmes

Unfortunately, due mainly to the financial constraints which the country has been experiencing over the past three years, the Programme did not develop as planned and some of the services that should have now been established have had to be "shelved" for the time being. Current services include:

1. **An Assessment and Guidance Centre.** Here, an average of 30 persons (of a full capacity expectation of 50) are prepared for employment and resettlement through the development of good working habits, counselling, JAMAL (adult literacy) classes, family life classes, etc. Since May 1976 when the Centre first began operations some 120 persons have received services of one form or another. The average period of time spent at the Centre is three months.

2. **Production workshops.** There are three production workshops that unfortunately are not yet fully self-supporting. These are situated in Kingston, in Port Antonio and in Lucea.
Twenty-five handicapped persons are regularly employed and have become skilled in batik and tie-dyeing, the production of woodwork items, such as wall plaques, toys, bread-boards, pot-holders, etc., silk-screening, making of soft toys and other crafts. I am pleased to say that since 1976 these production workshops and those connected to the Assessment and Guidance Centre have sold some J$22,000 worth of finished products.

(3) Rehabilitation workshop. A rehabilitation workshop has been attached to the infirmary in May Pen since 1976, and some 21 inmates there attend regularly. They produce a variety of items made from wood, coconut shells, bamboo, cow horns, carpet scraps, etc. Interestingly, the focal point of this workshop is the use of waste material and scraps to make saleable items which may be very much in demand.

(4) Office Training Centre. In 1975 the ILO again gave us tremendous technical assistance and today we have an Office Training Centre (which you are scheduled to visit) where 30 persons with various handicaps are trained in the different aspects of office work such as audio-typing, book-keeping and machine operating. The course lasts for 50 weeks. At its first graduation, 20 of the 30 students reached the required standard to graduate.

(5) Product design and experimental workshop. Also with the support of the ILO, a product design and experimental workshop was established and organised. It is currently being operated by Peace Corps Volunteers in an effort to save scarce funds. This project has met with a series of problems with the untimely departure of the two volunteers, but the Council is at the moment seeking to create other ventures such as ceramics and dried floral arrangements to keep the service alive. These will come on stream shortly and at least ten mentally handicapped persons are expected to receive training.

(6) Other related services. Other related services provided by the Council are those involving placement, the provision of special aids such as wheelchairs, artificial limbs, spectacles, financial assistance to purchase tools to establish persons in self-employment. Of special interest is the early stimulation project in the corporate area established and directed by Dr. Molly Thorburn and funded by the Government since 1977. Originally established by private funding three years ago, the project aims at improving the development of pre-school children who have any type of handicap through special stimulation and training applied as early as possible. Some 180 children are at present receiving this service with the help of specially trained child development aides.

Problems

Apart from the financial constraints referred to before, the programme has experienced a number of setbacks because of the unavailability of adequately trained personnel in this field. Also the majority of persons who have received vocational training or have been rehabilitated or received other services such as physical aids have not been absorbed into the workforce. With hundreds of able-bodied persons out of jobs, it has proven almost impossible to find jobs for the handicapped.
In an effort to overcome some of the problems encountered, full use has been made of training programmes established by the Caribbean Institute on Mental Retardation. In addition, use has been made of two of three fellowships provided by the ILO and of seminars and workshops conducted by voluntary organisations such as the Association for the Deaf, in an effort to expose the non-professional staff working in this programme to as wide a field of specialised work with the handicapped as possible.

On the question of placement, a number of low-capital input projects are being examined with the objective of providing sheltered employment for at least 30 more of the Council's "clients". At the same time proper "placement procedures" are being developed in collaboration with the Regional Adviser for the ILO in the Caribbean.

Not all the problems have been so relatively easy to deal with. Therefore the Council is at present evaluating its services, with special reference to the Assessment and Guidance Centre to determine whether or not that service is meeting its objectives, or whether any changes in its direction and objectives are needed. Already a number of issues are becoming clearer in this evaluation. These include the revision of the criteria for entry to the Centre, the reorganisation of staff, the replacement of some of the professional services by other types, proper record analysis, adequate staff training programmes and so on. It is expected that all aspects of the operation of the Centre will be studied by the Council and that its recommendations will be made to the Minister shortly.

Prospects for the future

Despite the brief but formidable outline just given regarding the problems connected to the Programme, the work of the Council continues in a positive way. Over the next five years efforts will be made, in collaboration with the ministries concerned, to see that basic educational, social and health services are made available to handicapped persons prior to their entry into the Vocational Rehabilitation Programme. Efforts will be made also to restructure the Programme so that its present inability to provide services for the multi-handicapped child can be removed. Then, too, the public will be made more aware of the socio-economic value of the trained handicapped person, and the serious scarcity of trained and committed personnel in all categories of rehabilitation disciplines will have to be dealt with.

These efforts will be set within the framework of a major plan yet to be approved by the Government, which has as its features the integration of services within the immediate community and a comprehensive and continuous service through using existing facilities in areas utilised almost totally by the able-bodied only. With the financial constraints in mind it is proposed to develop this approach on a regional basis, each region consisting of three to four parishes and providing those services most needed.

The development of those services over a period of time will be systematic and co-ordinated, with the "easier" services provided at the local level, others only at the parish level and the most sophisticated at the regional level. Back-up service will be provided by the central services which are already established in Kingston.
In closing, let me congratulate those who sponsored this Seminar - the ILO and the Danish International Development Agency - in their own attempt at changing the circumstances of the handicapped by bringing together representatives of different Caribbean and Latin American countries to share their ideas and to get new ones, to recognise more fully their responsibilities towards their disadvantaged brothers and sisters, and to ensure that disabled persons everywhere take their rightful place in the world of work and in the society.
4. Comprehensive vocational service systems for mentally retarded people - definition, principles and issues

by

Dr. Aldred H. Neufeldt

For those of us working in the field, the term "comprehensive vocational service systems" runs easily off one's tongue. It is safe to say, though, that the phrase hides a "multitude of sins", to sue an old saying. So, to try and expiate these, as well as to enunciate as clearly as possible the issues, this presentation will begin with an examination of some of the underlying concepts, followed by a description of comprehensive vocational service systems and how they might operate. Finally, for those participants who may be in the beginning stages of developing vocational services, some comments will be made about mistakes we have made which can be avoided.

A. Fundamental concepts

1. What do we mean by "vocational services"?

In western civilisation generally, our culture places a large amount of importance on adults having a "vocation" and "working" on something meaningful as a livelihood. At least, in the North American context (and I surmise this to be largely true elsewhere), the commonest first words of greeting on meeting someone new are "Hello, what's your name?"; and, "What do you do?" The phrase "What do you do" implies an expectancy that to be valued as a member of society one has a particular occupation which consumes a sizeable portion of one's waking hours.

Work, in this sense, is vital to one's definition of self. The absence of meaningful work, for many people, spells emotional and personal upset, often leading to a crisis of identity. The absence of meaningful work is a problem for many mentally retarded people. For these reasons, then, we have defined vocational services as those which either prepare a person for or provide support in meaningful employment and a vocational career.

2. What quality of vocational services?

It is clear that the kind of work one does has a greater or lesser attractiveness to it. Certain roles in society have commonly been considered of an inferior value, and others of a greater value. In recent years, it is evident that people occupying those positions historically classified as "inferior" have done much to redress the balance. Thus, again in the North American context, the assembly-line worker, tradesmen such as carpenters, plumbers and electricians, etc. earn more for their livelihood than do workers in the historically more desirable "white-collar" roles. One also has changes in terminology. We no longer have "garbage collectors", we have "sanitary engineers". All these factors are indicators of the cultural importance of work for a person's identity and for meaningfulness within society as a whole.
Though not a student of history, my readings suggest that this has not always been so. Some cursory reading of practices in the days of Greek civilisation suggest that the "worker" or "merchant" tended not to be considered a citizen. Indeed, frequently these individuals were slaves. Thus, work in the Greek context had a quite different meaning to it. On the other hand, Hebrews and the Judao-Christian emphasis over the years has had a different slant to it. Work from these contexts tended to be meaningful and something to be proud of. Thus, John Calvin and Martin Luther (to name but a few) viewed work as an exceedingly important ingredient of everyday life, and in fact elevated work to an expression of faith. This has led to what has been known as the "protestant work ethic". To avoid suggestions of cultural-centredness, it might be noted that work as such is also positively viewed in such other cultures as that of China, to name but one.

A further assessment of history, however, suggests that individuals who have been termed mentally retarded (indeed, other individuals who are also stigmatised by society) have not been the recipients of similar expectancies. Indeed, one wonders whether this has simply been a measure of "under-expectancy", or whether it is a subconscious societal discrimination which has suggested that handicapped individuals are not "worthy" of work.

The reason for mentioning these kinds of societal values and underlying ideologies is to underline the importance of the normalisation principle discussed earlier in this Seminar. The power of this principle is that it suggests that, if one wishes to enable retarded people to be more accepted for what they can contribute, it will be important that like work opportunities ought to be avialable for mentally retarded persons as for other individuals, and that considerable effort should be devoted to obtaining work that has a "societally valued" characteristic to it for any given individual. At least in our context we know that:

(a) active work is viewed more positively than that which seems passive;

(b) work with machinery, tools, automated equipment, etc. is positively impressive;

(c) rigour and self-discipline on the job is more valued than work which allows one to be messy and non-disciplined;

(d) a dignified, "adult" image of work and work products is superior to work that in other contexts might be associated with leisure activity (e.g. soldering electric circuit boards rather than rug weaving);

(e) a dignified image of funding source is better than one which has a charity connotation (e.g. we, for instance, strongly encourage our associations to avoid any mention of their association name, or even including our logo, on either the place of work they operate or on products produced so as to minimise this source of stigma);

(f) work which has greater earning potential is more status-enhancing than that which has less (one implication of this fact is that one may need to find ways of increasing productivity by automating work).
To the extent that we can optimise working opportunities on
the above kinds of dimension as well as others, to that extent we
are likely able to help retarded people be less stigmatised and more
accepted.

3. Vocational programmes as part
of "day programmes"

A second concept that has been found to have considerable
power is that of "modular programming". One of the greatest
problems in our various services is that they fail to provide
adequate support to either the individual retarded person or his
family. Poor co-ordination and discontinuous services impose on the
individual retarded person to the extent that we find broken
relationships with the persons they love and a general and
has observed that one of the reasons this happens is that the total
task of working with a severely disabled individual often falls on
a few individuals - very often family members, or a single agency's.
This tends to happen to the point that the family (or agency)
eventually gives up, following which the handicapped person's living
arrangements come to over-determine much of how the retarded person
spends his day. It is still the case in many instances that, if an
individual lives in an institution, his entire time is spent in the
institution. If he lives in a foster home, his time often is spent
largely with the foster family, to the detriment of both.

In contrast, most people find a living arrangement which
complements their day and evening activities. For example, a
student chooses a college and then finds an apartment; an adult
finds employment and then moves the family nearby. With mentally
retarded people, there has been a great tendency to find a place to
live and then worry later about what might be done in daytime.

In order to interrupt the traditional pattern of basing
programmes for retarded people so completely on where the person
sleeps, Lafave abandoned this approach and combined concepts of
normalisation and integration with the concept he called "modular
programming". Programme modules - daytime, evening and overnight -
are described as a way of designating where an individual spends his
time and is a way of structuring programmes so that the task of
working with an individual does not just fall on the family or on a
single agency, or any one group.

In this framework, the daytime module is given first
consideration. This focuses on educational, pre-vocational and
employment activities. The second priority module is the evening
module, focusing on socialising, recreation, chores, continuing
education, and self-care. Lafave found that with these two modules
in place the third module (overnight) was easy to contend with.
With an appropriate day programme chosen, and with leisure time well
looked after, then the question of where a person lives became much
more easily dealt with.

This modular programme approach seems to have worked well in
other places where it has been tried. As a concept, it also has
various simple yet powerful implications. The day module ought to
focus on those kinds of activities that relate to employment or to
the preparation of an individual for employment (in the case of an
adult not capable of employment). It also suggests that "leisure" types of activities ought to be left for a culturally appropriate time — evenings and week-ends. This concept, then, questions the practices of many of our sheltered workshops and activity centres (at least in North America) which tend to intersperse daily work-type activities with lengthy periods of recreation. There are sheltered workshop programmes that insist it is appropriate to go bowling every Thursday afternoon, etc.

Vocational programmes, then, are a vital segment of the "day module".

4. What do we mean by "comprehensiveness"?

It has been our experience that the term "comprehensiveness" has been used in varying and somewhat confusing ways. For instance, in some contexts a number of different services are housed under one roof, and this is termed "comprehensive". In other contexts, services are described as "comprehensive" (the implication being that all the needs of an individual will be met by that service), yet if on tracking through what an individual consumer of service receives one finds that "comprehensiveness" essentially is only one service. Everyone appearing for services gets treated with exactly the same programme, irrespective of need. The latter example is of course a blatant example of poor services. The former example, though, touches on an issue that we term "specialisation" and relates to the need to have modelly coherent and specialised services within a comprehensive service system.

The way we have used the term "comprehensiveness" is as follows: in a comprehensive system, the pre-conditions exist to provide each potential service consumer with no more and no less than the services he or she needs to maximise their capability.

It is important for the purposes of this discussion to note the difference between "specialisation" and "comprehensiveness". A specialised service is one that is coherent with respect to a specific model of what the service ought to be, and it meets the individual needs of individual consumers, or a relatively homogeneous group of consumers in a consistent way using specialised staff, methods and practices. Optimally, such a service provides one or at most a few closely related service functions. Thus, a "modelly coherent" and "specialised" vocational service is one that deals specifically with vocational issues and concerns, focused on vocational needs, and avoids getting involved with residential, leisure time, and other types of day programmes such as education programmes. On the other hand, a day programme that is to be "education" in nature does well to specialise in this capability and avoid getting overly involved with the other types of either day or evening and overnight types of programmes.

A comprehensive service system would be one where a sufficient range of modelly coherent service programmes or functions were developed, deployed and effectively co-ordinated so that service consumers would experience satisfaction and continuity in having their needs met without having to leave their specific geographic region. The concept of range of services (or service functions) and empowered co-ordination and regionalisation are all central ingredients in service comprehensiveness from this point of view. Figure 1 illustrates these various variables.
To be comprehensive, a service system usually needs to meet the following basic assumptions and imperatives:

1. a range of dispersed service functions;
2. strong and effective co-ordination;
3. a regionalised approach to service delivery; and
4. oriented to and reliance on structures and mechanisms for safeguarding and renewing the system and service quality.

Thus, in this frame of reference, true comprehensiveness is not achieved unless one has dispersed the various options for vocational training and/or employment. Modestly coherent vocational programmes would focus either on training or on service provision, but not likely on both simultaneously under the same roof.

B. Components of a vocational service system

Figure 2 illustrates the major components of a vocational service system. These are essential functions that should be present in a comprehensive service system. While these are described in more detail elsewhere (Durand and Neufeldt, 1975), the following provides a brief overview:

1. Recruitment. Recruitment refers to the way in which a potential consumer, client, worker or trainee may come in contact with a vocational service system. While there are a variety of possible ways, the most advantageous approach tends to be the one where a fixed point of referral in a geographic region will take the responsibility of referring persons requiring assistance with their vocation to a vocational service programme. Not only does this increase the probability that other services will be provided in a fully co-ordinated way, but this also tends to promote the development of the vocational services subsystem as well.

2. Selection process. An important element in vocational services is the decision of whether a person is entering the most appropriate day programme at first contact with a vocational service agency. The most optimum way to determine this is to involve the potential client in a needs-based review process which assesses both most optimum type of day programme a person should enter, as well as what other supports and/or programmes a person needs. The individual programme planning approach is one way of doing this.

3. Pre-vocational training. An important pre-condition to success on any job is such basic knowledge as what work is, how people relate to each other at work, etc. Normally, a person starts learning about what work and a career is all about at home. In the case of many handicapped individuals this learning process has been attenuated. Thus, supplemental opportunities need to occur - preferably within school settings. In a good number of places in North America we have seen the development of school-vocational programme co-ops, as well as the setting up of work-training centres which focus specifically on developing pre-vocational skills.
(4) **Vocational exploration.** This simply refers to trying out various jobs to test whether the kind of work involved is appealing and feasible. Ideally, and typically, a person develops an awareness of potential available careers early in life. Again in the case of mentally retarded people, this opportunity has either not been available or has been unrealistically approached. Very often mentally retarded people have particularly mixed notions of the fact that indeed they do have some capabilities. A deliberately planned period of "vocational exploration" to help mentally retarded individuals try various roles both gives the retarded person a more realistic opportunity to voice his/her opinion about the kind of work he/she would like to try as well as providing a good basis for evaluating likelihood of success.

(5) **Vocational skills training.** To be effective on a job in the open workforce an individual needs to have the specific skills that are important for that job. One of the fundamental purposes of a vocational service system should be to teach skills to individuals, skills that can be marketed and hence increase the employability of an individual.

(6) **Work adjustment training.** Before an individual is likely to receive a job in any unprotected workplace, or even a sheltered workplace, it is important that a person knows the requisite skills of what work is about. Again, many mentally retarded individuals have been short-changed in this regard as a result of lengthy institutionalisation or from other experiences that are equally abnormal. Work-adjustment training involves developing those work-related habits and skills important in every kind of work, but not necessarily part of the work itself (e.g. learning how to work, listen to and follow instructions, be punctual, etc.).

(7) **Personal adjustment training** is the training of social skills related to personal acceptance and success rather than on-the-job performance (e.g. grooming, self-care, use of public transportation, social conversation, etc.). If an individual has not acquired the appropriate social skills by the time the vocational training stage is reached, then a "personal adjustment" training programme needs to be introduced - though very frequently this can be undertaken during the leisure time (such as in evening programmes operated by community colleges, extension programmes of high schools, etc.).

(8) **Vocational evaluation - feasibility determination.** One of the more effective approaches to evaluation has been to ignore psychometric tests and just give a handicapped person the opportunity of gaining some experience in a number of occupations of their interest. On the basis of this exposure, the individual handicapped person can be appraised by a qualified craftsman, as well as the handicapped person making a self-appraisal. It is only as a result of the opportunity to try a number of different jobs in a variety of fields and receive the "feedback" from these experiences that a realistic choice can be made as to the type of work that is most appropriate for a given individual.

(9) **Placement.** On the way out of a vocational service setting to a regular work environment, or simply from one level of
vocational service setting to another, the placement function is most important. The most successful approach tends to be that in which a placement officer (perhaps the foreman on the vocational service job) begins with the specific skills and/or abilities of an individual handicapped person and then seeks out a placement for the individual. The reverse approach (start with a job and then try to fit the person) tends to lead to the proverbial "fitting of square pegs into round holes".

**Job stabilisation.** The process of making available to a person placed on a job on a continuing basis the supports needed to guarantee success on the job. Many examples might be cited that illustrate how a job placement may have been successfully effected, but that the work breaks down within a short period of time thereafter. In many instances this breakdown could have been alleviated through an adequate job-stabilisation programme.

**Retraining.** Once an individual has been successfully placed (whether in a sheltered or an open workplace), it becomes important that retraining opportunities are made available to keep work skills updated. Too often we forget that in the course of a working lifetime most people have at least four or five different careers. While the typical person in regular society has opportunities to have their skills refurbished through continuing education programmes, skills retraining programmes, etc., handicapped people frequently have not had the same opportunity.

C. The range of employment options

In the introduction we referred to the fact that a variety of service environments are required so that the diverse needs of mentally retarded adults can be met. Figure 3 illustrates the range required. Another way of illustrating the same array is through figure 4.

These figures illustrate that a continuum of employment opportunities needs to be available which range from dependence through to independence of the individual. Another way of saying this in terms of environments that are "protective" through "supportive" and eventually the natural environment. For comprehensiveness of such a continuum to exist, the following characteristics should be in evidence:

1. **Sheltered employment.** An employment service with a controlled environment, which is subsidised or requires subsidy because of relatively low worker performance capacity. Pay for work to individuals should be performance-based but will likely need to be subsidised. The work is meaningful and provided in a normal work environment with appropriate equipment, so that an individual can perform at an optimal level.

2. **Sheltered industry.** An industry that is operated to provide sheltered employment but is cost-benefit production oriented. Workers could anticipate minimum wage pay or better, depending on performance. The composition of the workforce might range from one which involves primarily handicapped persons — with
small work groups of non-handicapped worker-models - to one in which one-half to two-thirds of the workforce is non-handicapped.

(3) **Semi-sheltered employment** (group). A small group of handicapped persons working in a regular industry. These workers would be paid on a performance-based scale and should be expected to support themselves as any other employee of that industry. The difference between this step and sheltered industry is that in most sheltered industries a relatively small number of non-handicapped workers would work as a group within a workforce that is primarily handicapped, while in this instance the reverse holds.

(4) **Competitive work with support.** Handicapped worker placed into regular work setting in normal industry. Counsellor maintains regular contact to make certain that proper job stabilisation takes place. Properly developed, the TOJ programmes and others like it could fit this step.

(5) **Individual competitive employment and self-employment.** An individual person working in a regular job with no more continuing support than any worker typically receives, or an individual who is self-employed such as in operating a service that can be purchased on an individual contract basis (a homemaker service would be an example of the latter).

D. **To begin from the beginning**

One sometimes imagines it would be nice to begin a service system again to overcome mistakes that are in evidence in the so-called "developed" areas, but this is very difficult. A much greater possibility exists for this possibility in those places which are just now beginning to develop vocational services, both in our country and elsewhere.

The mistakes often made and some promising alternatives for the future include the following:

(1) **Many of our vocational services have no clear central reason for existence.** They claim to provide work, but much of what they do is mere activity. They try to "train", but to inappropriate ends. In other words, they lack what earlier we called "model coherency". The solution to this is simple. If one is going to begin a work programme, make it work-oriented in a normal sense. If you want a training programme, separate it off and make it training. The "work ethic" and business practice is most appropriate for the former, and an educational/developmental approach for the latter. Mentally retarded people need no longer be "clients" (a social work term), but could be either "employees" or "students", depending on the environment they choose as most appropriate at a given point in time.

(2) **As implied from the above, present vocational services providers often have over-relied on the advice of professionals who have expertise in everything but work.** Yet the appropriate expertise exists in almost every part of every country - the expertise of the business community. Many
problems in vocational services could be overcome if one challenged the business community to assume responsibility for organising the work opportunities for handicapped people. Perhaps what is needed is an alliance between the organised business/industrial community and other service providers - a consortium in which the business community organises the sheltered and semi-sheltered industries, and the others would do the preparing. This kind of an arrangement ought to be possible in the least economically developed areas of our world as well as the most developed.

(3) Another common problem is that vocational programmes are formed in isolation with no systemic link to other day programmes, or to other vocational services elsewhere. As a result they become the "dumping ground" for people rejected by everyone else with little possibility to help people escape. Why not rather arrange affairs from the beginning so that existing schools and colleges will undertake responsibility to do the training, and that the business/vocational service leadership develop a variety of work opportunities spread over a larger geographic area, each one different from the other. Then open the possibility of handicapped people moving from one place to another. This requires a bit more forethought. However, a multitude of new possibilities open up if one organises vocational services into this kind of "system". Not only will we see individual mentally retarded people choose careers most appropriate to their skills, we will increase the likelihood that handicapped people can develop as persons, to their level of independence.

References

Durand, I. and Neufeldt, A.H., Comprehensive Vocational Service Systems, National Institute on Mental Retardation, Downsview (Toronto), 1975.

Figure 1

COMPONENTS OF SERVICE SYSTEM COMPREHENSIVENESS

1 Wide range of services provided within reasonable proximity

2 Strength & effectiveness of coordination ("direction") of the relevant services in a region

3 Viable regional population size

4 Viable regional geographic constellation
   A) Clearly defined boundaries
   B) Manageable size, distances
   C) Manageable configuration, shape
   D) Manageable communication, accessibility

Subjective experience of continuity by consumer

Unitariness & interrelatedness of regional services

System manageability
COMPONENTS OF A VOCATIONAL SERVICE SYSTEM

RECRUITMENT
SELECTION
PRE-VOCATIONAL TRAINING
VOCATIONAL EXPLORATION
VOCATIONAL SKILL TRAINING
WORK ADJUSTMENT TRAINING
VOCATIONAL EVALUATION
PLACEMENT
JOB STABILIZATION
RETRAINING
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Enter system as far to the right as possible

Most restrictive

Most natural

Desired consumer movement after entering system
EMPLOYMENT CONTINUUM FROM DEPENDENCE TO INDEPENDENCE

LARGELY INDEPENDENT

Individual Competitive Employment
- regular workhours
- all workers treated equally
- regular industry

Competitive Work With Support
- non-handicap workforce
- with individual handicap persons
- with support

Semi-Sheltered Employment (Group)
- non-handicap workforce
- with groups of handicapped persons

Sheltered Industry
- largely handicap workforce with non-handicap worker
- models
- may be partly subsidized

Sheltered Employment
- all handicap workforce
- largely subsidized

Training

Work
5. Training of personnel for mental retardation programmes

by

Aldred H. Neufeldt

As the numbers and kinds of services developed in the fields of mental retardation and developmental disabilities expand, the question of personnel to provide such services and their preparation takes on increasing importance. As our expectancies of what mentally retarded people can do increase, more focused expertise often seems to be required. As the variety of services become more differentiated and complex, personnel must become at one and the same time more specialised, and yet more flexible. At the same time, personnel more than ever need a firm understanding of and commitment to aiding an underprivileged minority (which mentally retarded people are) to participate as equals in the life of the majority.

This presentation begins with a brief review of the relevant issues, and concludes with some of the current thinking on personnel preparation as it represents at least our experience in Canada on this topic.

A. Background issues

1. Who are we talking about?

In considering the question of personnel preparation, it is worthwhile to briefly review for whom we are preparing personnel. Presumably the nature and purpose for the "preparation" undertaken in large part will be determined by this - a presumption that admittedly is sorely tested at times if one looks at existing training programmes.

If one asks the question, "Who are the mentally retarded people requiring supportive assistance of a special nature?" the first conclusion one can easily reach is that mental retardation as such is not a unitary, nor one-dimensional characteristic. Mentally retarded people vary in age, in capability, in personal interests and so on.

From a planning point of view, another way to look at it is the proportion of population for whom special supportive and/or developmental services will be required. While according to various estimates approximately 3 per cent of the general population who might be described as mentally retarded, the fact remains that a large portion of these persons may require only short-term if any specialised support. Although the specifics might vary slightly, our experience has been that these "guesstimates" are reasonably accurate. In projecting adult service needs, our experience in several provinces now has been that if one plans resources for between 0.5 and 0.6 mentally retarded persons per thousand population, the fit of resources to demand is fairly close. The difference in these estimates (3 per cent versus 6 per cent) is explained, of course, by the fact that some retardation is only in
evidence "relative" to or in comparison to a larger group (this is most evident in the school years when there is a high demand for scholastic and social skills - the traditional determinants of retardation - are most in demand). Other forms of retardation, a much smaller portion, are recognisable in virtually any circumstance or society. The manpower implication is that it would be desirable for workers in almost all fields (education, health, etc.) to know at least a little about mental retardation, and a smaller number of personnel in more specialised roles to know more about this area.

2. Changing needs

Not only is there variability in the degrees of competence in evidence in the population for whom personnel are being prepared (hence placing some demands of flexibility on personnel), but there also is a marked change of need over time. Figure 1 illustrates how needs of mentally retarded people change substantially from infancy through old age. This corresponds very closely with what one finds in normal growth and development. However, many of our specialised services of the past, and those continuing to the present have assumed that medical needs were of great import throughout life. This illustration demonstrates that while the "medical model" of care may largely be appropriate in infancy and at old age, in fact medical needs tend to be very small in proportion to others in childhood, adolescence and early-to-middle adult ages. The implication for the planner of services, as well as for the policy maker and educational administrator, is that one has to plan for manpower of differing characteristics depending on the stage of development and age that our mentally retarded clients are. This becomes a fairly complex task of projecting rises and falls in numbers of people in various age categories in association with immigration/emigration patterns, birth patterns, etc.

3. Changing demands

A third important background variable to consider is our changing attitudes and values over time, and the fact that we have to "carry our past on our backs" as we attempt to promote change. Any system progresses from an early, relatively unstructured but dynamic character to one which becomes stable and systematised. While a stable system is important for ensuring "reforms" are put into place, such systems also need renewal. These kinds of changes associated with shifting attitudes and values have considerable implication for the number of specialised personnel trained, the kind of training given and the amount of training.

At an early stage of service development there tends to be an emphasis on obtaining essentially untrained personnel from wherever they might be obtained, with relatively small numbers of well-trained personnel. This has been true of both our institutional model as well as community model services. In an interim stage it was recognised that simple good will (and other motivations) was not sufficient for the large body of personnel. In-service training programmes for these people were required. Thus, for instance, we were involved in developing along with educators and service providers such personnel preparation regimes as a series of courses for "sheltered workshop personnel", a correspondence course for "early childhood service workers", etc. in the community; and a similar pattern had preceded these developments in institutions.
At some slightly later stage discussion began about the need for pre-service training. The pressure for pre-service training came first from the institutional context which had large continuing demands for personnel, these demands being relatively systematised as noted above. Similar demands are starting to appear in our community services as they become systematised.

However, a major problem has also resulted from this shift in demand. Within institutions across our country, in-service training was almost invariably dropped as pre-service training was put into place. As a result a gap in training occurs for those many individuals who either in the past or even in the present have substantial practical experience but little training. Elkin (1976) has noted that for many of these individuals a typical academic training obtainable in community colleges has been irrelevant.

Other problems also begin to surface. Pre-service training tends to lead to "professionalisation" (largely desirable), and then to increasing demands that more and more staff have substantial pre-training. The undesirable consequence is that training may become irrelevant, and certainly the cost of services will rise through increased salaries.

To solve this kind of problem, and to prevent others from arising, it would seem logical to begin thinking about personnel preparation in terms of the changing needs of mentally retarded people over time as referred to above. Given the varying needs depending on whether one is living at home, working somewhere in the daytime, or enjoying one's leisure time, suggests that various personnel models might be appropriate for differing contexts and that a single type of pre-service training for personnel in the field of mental retardation would not likely be by itself appropriate. Despite the fact that we have between 20 and 30 pre-service training programmes in Canada, for instance, there has in the recent past been a very clear message sent out from many parts of our country that the personnel from these programmes have little to offer for many community residential settings.

B. Questions for policy makers and planners

The above background points, which have at least been characteristic of Canada and I would suspect are characteristic of other countries with fairly developed services, lead to a number of questions which ought to be addressed.

First, what level of training is really required in the area of mental retardation? It is clear that in some contexts the level of sophistication required is greater than in others. However, do we want and/or need more highly trained personnel also tending to become more costly, and in many respects the increasing cost does not seem to be associated with improved returns. Balanced against this, are the pressures that one faces when one introduces untrained personnel who may make mistakes at the outset (often compensated for to some extent by enthusiasm).

Second, what type of training is required? To what extent should training be focused on technical skills, and to what extent should training be focused on orientation to the field of mental retardation, related fields, and basic ideological or value issues?
People like Blatt, Wolfensberger, and others, have very persuasively pointed out that pure reliance on technologies leads to inevitable devaluing of handicapped persons served. Thus, some emphasis on positive values such as the developmental growth potential of every individual, the principle of normalization, individualization, humanization, etc. are obviously needed. Balanced against this is the question of proportion of time that should be spent on technologies such as competence in working with language development, social skills development, motor skills development, etc.

A third question to be addressed is the role that practical experience plays in personnel preparation. One of the regular complaints that we hear from service providers is that personnel coming out of community college courses are not nearly as mature and appropriate to mentally retarded persons as compared to individuals with relatively little training who may be hired somewhat later in life. This is despite the fact that the largest portion of the graduates not only have fairly reasonable technical skills training, but also have usually an excess of 250 hours of supervised practicum experience. What credit in personnel preparation should, then, be given to just basic experience gained in the process of maturation of a person?

C. Models of approach

With these various experiences as outlined above, we have moved towards two complementary models of personnel preparation. The one has been known as the National Mental Retardation Manpower Model referred to above which had as its initial and primary emphasis pre-service training, but over time has become modified so as to allow for considerable flexibility in entry-exit-re-entry, carrying of credits from time to time, giving a credit for practical experience, etc.

The second model is of a supplementary, short-term training nature which we referred to as a continuing education system. The emphasis in this latter system is to provide new and current information in three basic categories: orientation and values issues; clinical and technological issues; systems and planning issues. The continuing education system is designed to provide current information in a short-course workshop or seminar format for a variety of audiences, ranging from parents and volunteers, to front-line service workers, to highly trained professionals and policy makers. This allows not only for "new" training for people just entering the field, it also allows for retraining and refurbishing of skills for personnel who have been in the field.

1. The National Mental Retardation Manpower Model

The National Mental Retardation Manpower Model was premised on several assumptions. First, that the largest proportion (an estimated 80 per cent) of personnel in the field of mental retardation did not require vast expertise, but rather fundamental knowledge of mental retardation, basic technical skills, and values. Second, for those 20 per cent there should be a balance between the specific formal training a person has, practical experience, and
personality factors in recognising a person's competence as a worker in the field. Thirdly, that there are many common areas of knowledge and skill involved in working with mentally retarded people, and consequently the Model is based on a broad concept of developmental handicap. In this context, the Model is basically non-medical on the presumption that chronically and profoundly mentally retarded persons comprise at most 20 per cent of even the institutionalised mentally retarded population. This group may need somewhat different kind of personnel (more medically oriented) than the bulk of mentally retarded individuals.

Figure 2 illustrates the broad nature of the kind of career-ladder associated with such training. A basic intent of the Model has been that one could enter training at any one of the levels. Levels I and II would usually take place within a community college context, the first involving one year of training, the second two years. Levels III and IV would take place in university, with varying degrees of specialisation associated. Further, at level I it was presumed that personnel having considerable experience might with very little training reach this level of designation, whereas individuals with lesser experience could reach this level of recognition with more training.

To date, curriculum guidelines and standards have been developed for both levels I and II. In the order of 25 community colleges across Canada are providing training in one or another of these areas, though not all have been rigorously evaluated against the national standard. Work is just beginning on levels III and IV, there being some considerable interest in varying parts of Canada to get this kind of training under way.

The biggest problem confronted by the manpower model has been that of inducing both community colleges and universities to adopt a "credit bank" type of system which would allow for easy entry and exit at varying points of time. A growing number of community colleges are developing a more flexible approach in this regard. This allows for individuals in the field to take individual short courses which might then add up as "credits" towards a given level certificate. A related problem has been to persuade universities to accept some or all of the "credits" given by community colleges towards knowledge within universities. This is a problem that is not yet resolved, though some promising signs are evident.

2. Continuing education system

In the past number of years, the National Institute on Mental Retardation has trained in excess of 6,000 people in various short-term workshops, seminars, etc. In this past year, for instance, over 50 short-term training events were conducted by NIMR across Canada. The content areas have been clustered into four broad categories - general orientation to mental retardation and values associated, technical competence areas, systems and planning-related issues, and changing trends for purposes of personnel renewal. As a result of the growing numbers of persons who had received varying amounts of training by this mechanism, and the kinds of problems with pre-service training noted earlier in this presentation, a study was undertaken to determine the most optimum way of bringing these issues together. The conclusion incorporated varying degrees of recognition for the varying amounts of training received. These
might be either independent of, supplemental to, or a part of the kinds of training events provided within community colleges or other pre-service training contexts. Indeed, the courses provided and recognised in the CES encompass all of these.

Figure 3 illustrates in general terms the kinds of courses provided and the associated kind of recognition that might be given.

D. Relevance to vocational services

On the basis of experience to date we are increasingly inclined to feel that the direction initially taken by the National Mental Retardation Manpower Model was essentially correct in that the largest number of personnel working in the mental retardation field seem to need relatively smaller amounts of training. This part of the model has proven itself to be very effective. However, the pre-service training approach by itself seems to be insufficient. Invariably, pre-service training programmes tend to become somewhat rigid and uncompromising, as a consequence of which services arise needing other kinds of personnel. This results in untrained individuals being hired. The continuing education system seems to us at this point in time as the means of overcoming these kinds of problems.

The specifics of how these apply to vocational services needs then to be addressed. If one adopts a philosophy of approach which: (a) distinguishes between work and training; and (b) within the work context distinguishes between the business aspects of operating a work programme, business, industry or what have you, and personnel supports one may have to build in, then the following would seem to apply.

First, on the "training" dimension of vocational services the requirements of the National Mental Retardation Manpower Model would seem to be appropriate. In fact, if emphasis is placed on finding personnel at the first two levels, this approach seems to work as well in economically depressed or underdeveloped areas, as well as more advantaged areas. This may well need, however, to be supplemented by in-service kinds of training along the lines of our CES.

Second, for the "work/career continuum" one essentially wants a workforce who already have appropriate skills (business management, peer model line-level worker, etc.) but simply need to have some orientation as to how best to use these in the context of both mentally retarded persons as well as in adapted work/industry. The most appropriate approach here would seem to be to supplement current skills with in-service training of the kind described under the CES above.
Figure 1

Sequential program needs of an individual with mental retardation and other developmental disabilities.
Figure 2

LEVEL IV
Training
Experience
Personality factors

LEVEL III
Training
Experience
Personality factors

LEVEL II
Training
Experience
Personality factors

LEVEL I
Training
Experience
Personality factors

CAREER LADDER:
A person may enter at any level

PERCENTAGE OF STAFF REQUIRED

JOB REQUIREMENTS

CANADIAN NATIONAL MANPOWER MODEL
National Institute on Mental Retardation
### Figure 3

<table>
<thead>
<tr>
<th>Level</th>
<th>Population</th>
<th>Criteria for accomplishing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Certificate of Accomplishment</td>
<td>Individuals who have been granted certification upon demonstration of proven leadership and evidence of positive innovative contribution to the field or to mentally retarded persons and who have continued efforts at personal self-renewal and continuing education.</td>
<td>At least an NIMR Certificate of Accomplishment (see below) or its equivalent.</td>
</tr>
<tr>
<td>Certificate of Accomplishment</td>
<td>Individuals who have shown a long-term commitment to continuing education and personal growth.</td>
<td>Active participation in a minimum of 8 NIMR courses, composed of 2 &quot;core&quot; courses and 6 electives (2 from each &quot;stream&quot;). Additional requirements at NIMR's discretion.</td>
</tr>
<tr>
<td>Letter of Accomplishment</td>
<td>Individuals who have taken some NIMR courses or are just beginning to participate in NIMR-sponsored events.</td>
<td>Active participation in a minimum of 4 NIMR courses including 1 from each categorical &quot;stream&quot;.</td>
</tr>
</tbody>
</table>

Diagram A
### Summary of streams

<table>
<thead>
<tr>
<th>Core courses</th>
<th>Clinical/technical</th>
<th>Systems/planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass Goal planning (to be developed)</td>
<td>Planning and development of comprehensive community-based service systems</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elective course areas</th>
<th>General orientation</th>
<th>Clinical/technical</th>
<th>Systems/planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation to mental retardation</td>
<td>Human development</td>
<td>Various sub-systems</td>
<td></td>
</tr>
<tr>
<td>Values</td>
<td>Development technologies</td>
<td>Voluntary association dynamics</td>
<td></td>
</tr>
<tr>
<td>Human rights and disadvantaged people</td>
<td>Measurement</td>
<td>Safeguarding</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of courses</th>
<th>General orientation</th>
<th>Clinical/technical</th>
<th>Systems/planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task analysis</td>
<td>Early childhood education</td>
<td>Vocational services</td>
<td></td>
</tr>
<tr>
<td>Current trends</td>
<td>Portage</td>
<td>Residential services</td>
<td></td>
</tr>
<tr>
<td>Normalisation</td>
<td>Sheltered workshop personnel training</td>
<td>Family resources</td>
<td></td>
</tr>
<tr>
<td>PAT</td>
<td>Behaviour modification</td>
<td>Citizen advocacy</td>
<td></td>
</tr>
<tr>
<td>Pass</td>
<td>Precision teaching</td>
<td>Protective services</td>
<td></td>
</tr>
<tr>
<td>Advanced pass</td>
<td>Vulpe</td>
<td>Guardianship</td>
<td></td>
</tr>
<tr>
<td>Causes and prevention</td>
<td>Individual programme planning</td>
<td>Voluntary association dynamics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Life skills</td>
<td>Planning and management issues</td>
<td></td>
</tr>
</tbody>
</table>

| Diagram B |
Job analysis and indeed techniques of training are the means by which we attain certain ends. Before discussing them, therefore, it seems appropriate to spend a little time considering the ends themselves. We must be sure of our reasons for wishing to train an individual in specific skills. We should take care lest our enthusiasm for technology should detract from the development of a sound underlying training philosophy. When training mentally handicapped people to perform work tasks we might ask two questions.

First, why has the particular task been selected? What relevance does it have to the needs and aspirations of the individual and to the likelihood of his making a better contribution to the community to which he belongs?

Second, what particular learning difficulties does this individual exhibit? What do we know of him as a result of our previous experience when training him to perform tasks?

I believe these two questions are crucial if we are to obtain a correct sense of perspective - we can best consider them within the framework of a "curriculum", a term which still seems to be appropriate when describing the integration of pre-vocational and vocational training programmes within an over-all framework of training in areas including self-help, social-academic and interpersonal skills. The principles involved in developing such a curriculum have been considered in more detail elsewhere (Whelan, 1976).

Too often jobs are provided because they simply happen to be there, they are the most readily available. During visits to vocational workshops in various countries one continues to see a preponderance of manual assembly work, involving such operations as folding, glueing, stapling, labelling, sorting, counting and packing. For too long there has been a false assumption that this is the kind of work that is best suited to mentally handicapped people. Indeed, recent surveys have shown that over 60 per cent of work carried out by mentally handicapped adults in such workshops is of this type (Wansbrough, 1971; Whelan and Speake, 1977). It is often found to involve little skill, to be repetitive, to be meaningless to the trainee, and to have little training value.

This type of work, becoming known to those who attend international conferences on vocational rehabilitation as "Mickey Mouse tasks", is in high contrast to the wide range of jobs to which mentally handicapped people go when entering employment. An example of this range may be seen in the following table:
Table 1: Types of jobs taken by trainees who enter open employment

<table>
<thead>
<tr>
<th>Job categories</th>
<th>Years previous to survey</th>
<th>Year of survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janitorial and housekeeping</td>
<td>204</td>
<td>134</td>
</tr>
<tr>
<td>Industry</td>
<td>330</td>
<td>282</td>
</tr>
<tr>
<td>Laundry</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>Food services</td>
<td>85</td>
<td>59</td>
</tr>
<tr>
<td>Agriculture/horticulture</td>
<td>97</td>
<td>53</td>
</tr>
<tr>
<td>Animal care</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>General services (municipal)</td>
<td>68</td>
<td>23</td>
</tr>
<tr>
<td>Patient care</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Garage and mechanical repairs</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Office and shop work</td>
<td>51</td>
<td>42</td>
</tr>
<tr>
<td>Building and allied trades</td>
<td>54</td>
<td>29</td>
</tr>
<tr>
<td>Sports</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Personal service</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>General labouring/handyman duties, etc.</td>
<td>68</td>
<td>50</td>
</tr>
</tbody>
</table>

From Whelan and Speake, 1977.

Perhaps the best way of illustrating the importance of developing a balanced vocational rehabilitation curriculum or programme is to reproduce the vocational rehabilitation lattice developed by Budde and Menolascino (1971). The over-all goal of the programme is depicted in the top right-hand box "optimum vocational habilitation" (see figure 1). Reading the lattice from left to right we see the different stages of training, showing how basic social skills, job-related social skills and eventually placement-related social skills are integrated into the various stages of work skills training.

Let us now assume that an appropriate job or task selection has been made. Then how does task analysis relate to the process of training? To understand this better it could be helpful first to consider briefly the learning process itself and thereby discover something more of the various ways in which a learner may experience difficulty.

The learner and the task

From a good deal of research within the information theory framework, psychologists can now put together a "model" of the learning process. This is shown in figure 2.
Figure 1. Simplified version of a programme lattice (from Sudek and Fenalecino, 1971).
Figure 2. A diagrammatic representation of the way in which total information-processing capacity may be shared between various functions, depending on the nature of the task.

The "model" shows the interaction between a learner and a task. This consists of a number of stages and research has shown that mentally handicapped people often have difficulty with one or more of these stages. A more detailed discussion of this model is provided elsewhere (Whelan, 1974). One important point to note is that the link between the learner and the task, the achievement of an effective "loop", is a function not only of the learner but also of the type of task. Some tasks make great demands on perceptual skills, involving close attention and concentration, others require a good deal of decision making or the exercise of judgement, whilst others may require more of the individual's "capacity" to be devoted to fine or precise movements. Thus, the particular task determines what scope there is for learning. If we regard a learner as having a certain amount of "capacity" available for dealing with the information from the task, then an information overload can occur within the various sections separated by the dotted lines in the figure. Careful and thorough task analysis can enable us to anticipate the type of demands to be placed upon the learner by a particular task and to spot where "overload" may occur. A procedure for diagnosing the type of learning difficulty which an individual may be experiencing is facilitated by reference to the stages in the figure. Tasks should be selected with such factors in mind.

The value of task analysis

When a task analysis is written out then it becomes possible to select the appropriate teaching method, adapting the method to the different type of problem which the learner may face in different parts of the same task. For task analysis to be possible it is essential that observation of the performance should be made. Some basic requirements of this performance are that it should be (1) carried out by an experienced person; (2) consistent, with hardly any variation in the method used; and (3) repeated to enable viewing several times.
If the task is familiar (for example, a self-help one) the analyst may choose to monitor his/her own performance - but it is always better to observe another person. It may be noted that the early exponents of industrial job analysis systems often used 16 mm film and carried out a painstaking frame-by-frame analysis of the movements involved in several shop-floor operations (for example, Maynard et al., 1948). Nowadays, much reliance is placed on VTR (the familiar "action replay" beloved by TV sport commentators) which is becoming less expensive.

"Analysis" basically consists of a listing of discrete operations in the sequence in which they are carried out. For some purposes it may be necessary to record what each hand does separately. This facilitates "methods engineering" - for example, spotting those points in the task where the hands could assist each other, or perform simultaneous rather than alternate operations, thereby shortening the over-all "cycle time". Analysis can enable points of recurrent difficulty to be spotted - perhaps an improved work layout, repositioning the feed tray or introduction of a new tool, or use of a jig will make this operation either more accurate or less fatiguing - in other words, improve efficiency.

When drawing up the recording schedule it may be helpful to consider listing the successive steps upwards, from the bottom of the sheet. An example is shown below, in figure 3, of the value of this approach.

Figure 3 shows the learning curve of a trainee being taught to assemble part of a gas meter. The curve shows that job element number 8, involving an asymmetrical fit, proved to be the stumbling block on 8 of the 16 trials required to reach an errorless performance.

Experience with a number of individuals learning the same task will enable recurrent points of difficulty to be identified. This may mean that a task should be modified - it should also suggest that pre-training would be valuable in the type of operation which is causing difficulty for many trainees. Using real jobs in this way, sometimes referred to as the "work sample" approach, we can thus develop a useful, though limited, assessment and training facility; useful because it becomes possible to develop a reliable yardstick for measuring an individual's performance, limited because any job consists of a unique set of operations and thus provides only a restricted set of experiences.

At this point we may summarise the value of task analysis as follows:

1. it enables a step-by-step teaching plan to be developed;
2. it alerts the instructor to potential areas of difficulty and suggests the value of a particular task within a graded programme of work experience;
3. it facilitates the plotting of a learner's response to training;
Figure 3. A sample learning curve - assembly of a gas meter component.

Stages in the task:
1. Get plate with L.H.
2. Check orientation of pear-shaped incision
3. Place in jig
4. Get flag with R.H.
5. Locate small rod end through R.H. pear incision
6. Align rod with pear incision opposite
7. Get first pear plug
8. Locate pear plug in pear-shaped incision
9. Hold flag with L.H.
10. Get second pear plug
11. Locate pear-plug in R.H. pear-shaped incision
12. Get e-clip holder
13. Secure an e-clip
14. Locate over first groove in flag
15. Secure second e-clip
16. Locate over second groove in flag
17. Place completed assembly aside with e-clip holder
it enables a yardstick to be developed against which an individual's performance may be compared. If a standardised industrial method of task analysis is applied then the "standard time" allowed for a normal operative may be used as an index of a trainee's likelihood of performing in a way that would be satisfactory to an employer.

The same basic principles apply in all task analysis. Some examples from the area of self-help should be considered in illustration of this.

Task analysis as a basis for the teaching plan

It should be stressed that the discipline involved in carrying out a thorough task analysis is fundamental to sound teaching. The "teaching plan", however, is more than the task analysis, although it is built around the latter. The teacher/instructor must also give due consideration to procuring the necessary resources (materials, time, space, personnel) and the language to be used (the minimum vocabulary and/or sign system to be employed), the method by which the learner's progress will be recorded, and so on. It is highly desirable that this over-all teaching plan should be written down in advance so that experience may lead to its revision and improvement over time. With the increasing demand on accountability in the field of vocational rehabilitation many agencies or training establishments are now familiar with the requirement that programme planning should be systematic and properly recorded.

Standardised methods of task analysis

If a standardised industrial method of task analysis is used (for example, basic motion time, work factor or methods-time measurement) then communication is facilitated between the training facility and industry at large. Most predetermined motion time systems operate with the full support of the unions. The system which we have used, because of its widespread application, is HTM-2. This is derived from basic HTM (consisting of 26 elements), and the categories are shown in table 2. From an examination of all the systems in operation we discover that certain elemental, or basic, operations are common - they are the "building bricks" out of which any actual job performance is built. They provide us, in the prevocational workshop, with an important insight into the essential ingredients of our basic training. We have developed this notion, during work which commenced in 1969, and have incorporated it in our work skills training kit.

The work skills training kit is intended to supplement the tasks which may already be available, in the form of subcontract or own-product work. It provides a convenient storage facility in addition to work stations for the instructor. Flexible in use, it allows intensive practice in elements of work which are common to many real jobs. It covers such operations as sorting, fine discrimination, positioning, eye-hand co-ordination, use of basic tools, reaction to "emergency" signal, and so on.

The rationale for determining the content of the work skills training kit has been developing over several years and takes
account of research into industrial skills as well as our knowledge of the types of learning difficulty experienced by many mentally handicapped people. The ingredients of MTM-2, shown in table 2, have influenced the design of the kit.

**Table 2: Categories which constitute the MTM-2 system**

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
<th>Category</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Get</td>
<td>GA</td>
<td>5. Eye action</td>
<td>E</td>
</tr>
<tr>
<td></td>
<td>GB</td>
<td>6. Foot motion</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>GC</td>
<td>7. Step</td>
<td>S</td>
</tr>
<tr>
<td>2. Put</td>
<td>PA</td>
<td>8. Bend and arise</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>PB</td>
<td>9. Weight factors</td>
<td>GW</td>
</tr>
<tr>
<td></td>
<td>PC</td>
<td></td>
<td>PW</td>
</tr>
<tr>
<td>3. Regrasp</td>
<td>R</td>
<td>10. Crank</td>
<td>C</td>
</tr>
<tr>
<td>4. Apply pressure</td>
<td>A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Our research programme has included the use of certain tasks currently being performed by semi-skilled fitters in industry which have been subjected to video recording and MTM analysis. Studies involving individual and group instruction, the use of television, of programmed pictorial manuals, and instruction of one trainee by another trainee (pyramid teaching) have been carried out (Tomlinson, 1976).

**Summary of teaching principles**

During our research programme and our reading of other published studies, it has been possible to draw up a list of hints for practitioners concerning the most effective teaching strategies:

1. analyse the task into discrete operations, enabling the learner to be presented with a small step at a time. In the case of industrial tasks, predetermined motion-time systems are valuable in providing a standard job method and performance time;

2. each operation must be carried out correctly before the learner is allowed to proceed to the next step. Incorrect performance can result in habits which have to be unlearned;

3. language and gestures to be used should be clear, unambiguous and consistent. An economy of language should be observed - during later stages of mastering the task the learner's task-relevant vocabulary may be extended;

4. the learner must receive knowledge of results. During early stages of learning, correct performance should be rewarded
immediately, by verbal praise for example. As the learner progresses the instructor's silent interest usually serves as sufficient reward until the task is completed when verbal praise or another suitable reward may be given;

(5) the learner should be given an opportunity to correct his own mistakes where possible. A non-specific signal, in the form of words, a buzz or a flashing light, for example, can be used to indicate that an error has occurred whilst leaving scope for the learner to discover the type of error and to correct it;

(6) teaching sessions should be spaced out over time. Three sessions of 20 minutes each will be more effective than one session of an hour;

(7) teaching should continue beyond the point at which the learner has achieved one errorless performance. Several more performances at this stage help the individual to "over-learn" and greatly reduce the likelihood of the correct method of performance being forgotten;

(8) make use of the different senses during teaching. It may be possible to help the learner not only to see but also to hear what is involved. Correct movements may be "moulded", for example, by standing behind the learner and guiding his hands in carrying out the necessary movements;

(9) opportunities should be provided for new knowledge or skill to be transferred to different settings. Initially, as many elements as possible which are similar to the previous setting should be made available, gradually making the situation less familiar as transfer of the skill is accomplished;

(10) involve the learner in every stage, discussing the advantages which the new skill has and showing your enthusiasm for the progress which it represents;

(11) the learner should be given an opportunity to show others how the task is performed. The chance to act as a teacher is one which many mentally handicapped people greatly appreciate. Under appropriate conditions they can be most effective teachers and it is important that they should not always feel that they are on the receiving end of help;

(12) it is often as easy to teach a group of individuals as it is to teach on a one-to-one basis. Appropriate arrangement of work stations to enable a demonstration to be viewed by all, and care in carrying out quick checks on individual performance at each stage can enable the group to keep together in following the instructor, for example in an industrial assembly task. It is possible to teach as efficiently groups of three, six or ten individuals in this way as it is to teach one person at a time.
References


7. Basic work skills training and vocational counselling of the mentally retarded

by

Dr. Edward Whelan

The main community-based service for the rehabilitation of mentally retarded adults in Britain is provided by the Adult Training Centres (ATC). Some 32,000 trainees attend on a daily basis; the majority live at home with their families and have some accommodation in hostels or flats. The ATCs cater mainly for moderately and severely mentally retarded adults, although a small number of mildly mentally retarded adults can be found in every ATC. A recent national survey of ATCs (Whelan and Speake 1976) has shown that their general aim is to develop the trainees' work habits, work skills and social competence and wherever possible to direct them to sheltered or open employment. The major emphasis in training in the area of "work skills" may be understood in terms of the historical development of ATCs under the influence of a number of factors including: the official guidelines provided, the background from which many of the staff are selected and the general views of society itself, reflected through the views of service providers, parents and of mentally retarded individuals themselves. Nevertheless, actual employment success is very low indeed (less than 5 per cent) despite reliable staff estimates that over 11 per cent of trainees could succeed in open employment and a fair 25 per cent in sheltered employment if places were available.

There are obviously many factors that influence the outcome of a training programme when it is measured in terms of employment success. Many of these factors (e.g. the local level of unemployment) are largely independent of the training centres even though the staff may be collaborating closely with placement officers. For this reason ATC staff agree that they should concentrate initially on improving their training programmes. In addition to a growing awareness that the ATC should become more "educational", using that term in its broadest sense, staff are keen to become more effective instructors and to apply more systematic methods in their everyday work. It is important that research should be shown to be relevant by focusing first on areas that are of immediate concern to staff. For this reason our team has mainly concentrated on work skills training.

Of those trainees who are successfully employed, only about one in three enter a job that is similar to anything they have experienced during training. The survey also revealed that little was known about the job interests of the trainees. A study of the skills and the equipment available within the ATC and the way in which its daily schedule is organised, suggests that it is best fitted to provide a general pre-vocational form of training rather than preparation for specific jobs. Included in this should be such basic work skills as recognition and use of basic tools, manual dexterity and co-ordination, ability to follow instructions, attention to safety, development of good work habits, together with other (social) skills specifically related to the work situation (e.g. co-operation, teamwork and appropriate response to supervision). The latter should be dealt with by the planned programmes of social education - I wish to focus here on the work
skills themselves. In a previous review of this topic (Whelan 1973) the types of training situations that may be made available were listed as follows:

1. in-placement training on a specific job;
2. within-the-unit job experience;
3. simulated job training;
4. synthetic jobs; and
5. perceptual motor training devices.

Work skills training kit

Attempts to develop a comprehensive scheme of basic perceptual motor training, a "work skills training kit" commenced in 1970. The results of applying the first version of this have been very encouraging and recent collaboration with an industrial designer has resulted in the new "work skills training kit", the prototype of which has just been built.

The aim was to design a mobile piece of equipment that would enable all components of this kit to be presented in turn and stored when not in use, with space for further items to be added later where necessary; it should be attractive in appearance, suitable for use in workshop or even classroom settings and include a certain degree of automated recording of performances.

The various components of the kit have been determined as a result of an intensive review of the elemental operations that can be found in various combinations in any job. Important influences in this analysis have been the various predetermined motion time systems that are widely used in industry, the consensus concerning items included in many scales for assessing work skills and the particular areas of performance that research has shown to present difficulties for many retarded individuals (Grant 1971; Grant et al. 1973, 1975; Whelan 1971, 1973, 1974). The theoretical basis of the approach is supported by many studies of transfer of training which have shown that transfer most readily occurs when the initial learning task and the transfer task are quite similar (Drew and Espeseth 1968). The work skills training kit should be used by practitioners to supplement the "work sample" approach.

It should be noticed that the emphasis is on training, though it is clear that the distinction between assessment and training is no longer clearcut in practice. The kit will provide a valuable profile of perceptual motor skills together with measures of other relevant skills (such as decision making, memory for sequences and specific discriminatory ability). It provides both an indication of present abilities and of further training needs and should not be used to make predictive inferences about an individual's ability to respond to training.

The performance norms, soon to be developed from a representative sample of trainees in adult training centres, will make use of the shape of an individual's performance curves for each task presented on several occasions. The absolute value of their
performance, in relation to acceptable industrial standards, will be readily afforded by the references to the standard time for each task, defined by a methods time measurement (MTM) analysis. This standard time will appear as a horizontal line on the scoring sheet provided for each task.

In order to obtain some measure of transfer, the work skills training kit will include two composite tasks, for each of which a pictorial programmed manual is provided. The trainee is taken through the first manual by the instructor, who shows him how to perform the task using the various components and carrying out the necessary operations in the order and manner illustrated in the manual. Once the trainee has learned the use of the manual in this way the instructor replaces it with a second manual, together with a new set of components, and monitors the trainee's attempt to complete this novel task solely by reference to the pictorial manual. If trainees are able to acquire this self-instructional strategy, then the implications for the design of new manuals, both for use in the workshop and in the social education area, are considerable. Once we are sure that each trainee is capable of performing the basic operations that are the building bricks of any task, surely an important function of pre-vocational training, then we are able to present him with tasks that make successively greater demands on his skills, allowing progress to be reflected by his movement through the various departments in the unit—from the induction workroom to the most advanced workroom where more specialised job training is available prior to placement in his employment. Successful techniques of training on real tasks have been described by a number of workers (Crosson 1968; Screven 1971; Gold 1968, 1969, 1972, 1974; Tomlinson 1976).

The Illustrated Vocational Inventory

The survey of adult training centres showed the need for staff to learn more about the job knowledge and job interests of trainees. When staff do enter into conversation, it is usually in a group setting and although it plays an important part in establishing friendly relationships "chatting" is no substitute for a purposeful and systematic attempt to involve the individual, listening to his ideas and encouraging him to express them where difficulties are found. Staff concerned with the vocational planning, training or job placement of individuals need to obtain systematic information about their interest patterns in the many unskilled and semi-skilled jobs that are, or could be, made available to them.

Although a large number of sophisticated tests of vocational interest are available for use with non-handicapped individuals these usually require a high level of reading ability and comprehension. A small number of tests of vocational interests are available for use with mentally retarded individuals, including the vocational interest and sophistication assessment test (Parnicky, Kahn and Burdett 1971) and the reading-free vocational interest inventory (Becker 1973). However, all the known tests were designed for use with border-line or mildly mentally retarded adults. Attempts to apply these to more severely retarded adults resulted in the conclusion that a new instrument is required when working with this group. In addition, it found that the use of line-drawings introduced some ambiguity and the provision of fewer occupational categories for females than for males provided unnecessary limitations in some tests.
It was for these reasons that the Illustrated Vocational Inventory (IVI) was designed. It is a reading-free instrument which provides a framework for staff to explore the vocational knowledge and interest of moderately and severely mentally retarded individuals. The IVI is based on 11 areas of work, a common list of occupations to be used with both males and females:

1. domestic work;
2. simple factory;
3. industrial laundry work;
4. food service - catering;
5. horticultural/agricultural work;
6. animal care;
7. local services;
8. patient care;
9. garage work;
10. office and shop work;
11. building and allied trades.

Several considerations lead to the choice of the above list of occupational areas. A survey of research and reports concerning jobs held by mentally retarded persons, for example that carried out by Collman and Newlyn (1956) indicated a wide range of possible occupations. The national survey of adult training centres also provided information concerning the range of jobs successfully held by ex-ATC trainees in open employment.

During pilot studies (Reiter 1976) it was found that photographs are more effective in stimulating verbal responses from trainees than are line-drawings. The IVI, therefore, is based on a large number of monochrome photographs. Large numbers of photographs were taken of people in the course of normal work and finally 11 representative photographs were selected as representing each occupational category. One photograph from each category is used in the occupational knowledge inquiry and ten from each in the interest inquiry. The occupational knowledge inquiry consists of 11 large photographs, one for each of the work areas listed, with an extra photograph at the beginning to serve as a practice example and for subsequent reference. Six basic questions concerning general aspects of the work are asked about each picture in turn.

The occupational interest inquiry consisting of 110 photographs (10 representing each work area) involves a forced-choice procedure. Every occupational area is matched with every other one, resulting in 55 paired photographs each on a separate page.

The individual is asked to indicate which of the two tasks depicted by the photographs he would prefer. In five of the ten cases the picture representing a particular occupation appears at the top and in five cases at the bottom of the page, to overcome any possible response bias.
The IVI has now been administered to over 400 trainees and raw scores have been converted into percentile distributions for males and females separately on the two inquiries (figures 1 to 4). Measures of validity and reliability have been carried out on the IVI, a handbook has been prepared and the new instrument is now in process of publication.

When applied to children in their final year at special school, it was found that the IVI knowledge inquiry would need to be supplemented by more detailed questions if it is to become applicable to mildly retarded school-leavers. This inquiry was found, however, to be suitable for the severely mentally retarded schoolchildren, most of whom will proceed to the ATC at the age of 16 years. The occupational interest profile of both groups of children fell within the average range obtained by ATC trainees.

Both of the techniques that have been described in this paper are intended for use by practitioners. One of the aims of the research team has been to enhance the professionalism of the ATC and associated staff by giving them a share in the skills that often have been regarded as the monopoly of more highly trained professionals, such as psychologists. We believe that staff who have been taught how to use a new technique will be more likely to incorporate that area of training within their daily programme and to experience an increase in job satisfaction which will ultimately benefit those whose futures depend upon their professional skills and standards of practice.

Summary

Two new techniques have been presented for use in the pre-vocational training of moderately and severely mentally retarded individuals. The work skills training kit allows intensive practice of those basic operations required in combination in any task. The Illustrated Vocational Inventory is a reading-free test of vocational knowledge and interest.

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OCCUPATIONAL KNOWLEDGE

Scores

High
Average
Low

12
11
10
9
8
7
6
5
4
3
2
1
0

occupations

Figure 1 — Male

Scores

High
Average
Low

12
11
10
9
8
7
6
5
4
3
2
1
0

occupations

Figure 2 — Female

J — Janitorial & Housekeeping
I — Industry
L — Laundry
F — Food Services
A — Agriculture
AC — Animal Care
GS — General Services
P — Patient Care
G — Garage & Mechanical Repairs
O — Office & Shop Work
B — Building & Allied Trades
IVI INTEREST PROFILES

Figure 3 — Male

Scores

High
Average
Low

occupations

J — Janitorial & Housekeeping
I — Industry
L — Laundry
F — Food Services
A — Agriculture
AC — Animal Care
GS — General Services
P — Patient Care
G — Garage & Mechanical Repairs
O — Office & Shop Work
B — Building & Allied Trades

Figure 4 — Female
References


8. The transition of the mentally retarded from special school to work

by

Mrs. M. Brown

"The development of a work personality results from a process which begins in early childhood."

From: Vocational preparation of retarded citizens, Donn E. Brolin, Charles E. Merrill Publishing Company, 1976

Rationale

In most communities values are related to the economic activities necessary for survival and are thus functional in a sociological sense. In as much as they are shared, they have a public aspect, and are expressed symbolically by means of titles, possessions, public roles or other externally visible designata. But these values have an inner meaning as well; they form the basis for self-evaluation, reinforcing for each individual his sense of personal worth. Therefore, we can easily recognise the fact that a positive self-evaluation is a requisite for the mental health of the individual in any culture. It is not quite as frequently recognised (though it has long been expressed) that such a positive self-evaluation can come through the response of others to one's own action and behaviour.

It is this, which could be called "the need for positive effect", which is a central and essential dynamic in the human motivation system. This matter has both a public and private aspect; that is, there is the matter of our privately held self-image and its adequacy in relation to the generally held standards of our society, and there is also the public presentation of the self, our management of interpersonal relationships so as to obtain a satisfactory appraisal from the outside world. The private image is created and reinforced from public response; and this self-image is built out of the public reactions to behaviour.

But among the mentally retarded this problem is doubly exaggerated. First and foremost, their problem lies in the fact that their stigma - of all possible stigmata - is closest to what we may call the soul. Of all the attributes of man, mind is the quintessence; to be found wanting in mental capacity - in general intellectual competence - is the most devastating of all possible stigmata. Their difficulties are compounded by the fact that their incompetence itself hampers their ability to manage their public life so as not only to hide from others the reality of their stigma but, even more important, to receive confirmation of their own competence.

The mental retardates have less cultural clothing to hide their drives which motivate their actions; they are less capable of dissembling the actual in their desires, thus giving clearer expression to the generic orientation in man the need for positive effect.
Therefore, a programme of rehabilitation should help them to weave their garment of concealment so that they may escape the psychological inroads that their past makes upon them. Training in those areas of life that are requisite for minimal competence, but which escape the attention of the competent as being too trivial, would be one of the first steps. Those of us who are competent are generally unaware of the cues to which we respond automatically, for they are not in our consciousness. The mentally inadequate must not only be told, they must repeatedly be told; indeed they must be drilled in proper social responses to normal social situations.

"We cannot make them what they are not, but we can make their lives more comfortable, more nearly satisfying and more useful."

From: The cloak of competence, Robert B. Edgerton, University of California Press, 1967

The Curriculum Construct for the Mentally Retarded must therefore affect parents, teachers and students.

The school programme should therefore provide the following Curriculum Construct (measured both by a developmental (spiral) progression and a balance/emphasis in the instructional management of the TOTAL CHILD):

(a) Motor development:
    objective: to demonstrate adaptable balance.

(b) Language development:
    objective: to speak in complete sentences.

(c) Behavioural development:
    objective: to channel anger in an appropriate manner.

(d) Experimental development:
    objective: to estimate (money),
    to budget (money).
Pre-vocational schema

Boys' workshop

16-18 years
Full time

14-16 years
Full day per week

Girls' workshop

16-18 years
Full time

14-16 years
2 periods per week

12-14 years
1 period per week

on-the-job training
16-18 years
- community employment

Post school - 18+ year olds referred:
- to Jamaica Council for the Handicapped for assessment/evaluation and job placement
- to Jamaica Mentally Handicapped Council - adult workshop (sheltered workshop)

Staff involvement:
- monthly in-service seminars,
- curriculum guidelines (unit teaching),
- required projects/papers.

Parent involvement:
- report system,
- small group parent-to-parent sessions,
- Parent Teachers Association,
- individual conferences.

Community involvement:
- fund raising (class projects),
- volunteer (Leons, Rotary, Kiwanis),
- JAMAL (Adult Literacy Programme),
- trade training centres.
9. The role of parent and volunteer organisations

by

Mrs. Y. Posternak

Beginnings

Until recent times, the mentally retarded were a forgotten group: they still are a neglected and disadvantaged group in many parts of the world, not only in emerging nations where poverty, malnutrition, illiteracy and disease call for many urgent services, but also in areas of industrialised wealthy countries.

Until about 1950, in Europe and in the North American continent, the old concept of charity towards a segregated population of mentally handicapped persons was dominant but thankfully, today, the principle of responsibility starts to prevail. We are grateful to the pioneering work of private welfare associations who first tackled the vast problem posed by the handicapped at a time when the State paid practically no attention to them. But the goodwill of a few could neither quantitatively nor qualitatively alleviate the pathetic life condition of the retarded. The picture has been too often one of indifference, prejudice and disregard. It was the burning conviction that authorities and professionals were largely disinterested, that drove and still drives the parents of retarded persons to revolt against such neglect and to the establishment of volunteer societies.

Different types of societies react in a great variety of ways. The movement is still continuing, spreading to a great number of developing countries and involving not only parents, but citizens who believe in the rights of their fellow countrymen.

Whoever is sincerely interested in the breaking down of colonial, racial or socio-economic restrictions should also feel strongly about the plight of mentally handicapped persons who also pose a problem in the quality of their citizenship. I must emphasise therefore that one of the most foolish misconceptions is the belief that one can build independent, responsible nations by setting aside the handicapped.

Even the poorest country can do something within the normal range of social, residential, educational, vocational and medical services, instead of waiting "for better times". Planning even small but effective pilot services in the early stages of national development is like planting a seed; it is clearly not only more humane, but will in the long run be more economical. The problem must of course be studied in the light of modern options for the handicapped.

Changing policies - societal integration

Today, emerging nations as well as industrialised societies are beginning to recognise that the majority of mentally retarded persons can live in the community if necessary supportive services are provided to them and to their families. The changing views, those now coming to predominate, are in considerable contrast to the
model of custodial care in big institutions which are costly to build, difficult to staff and where a mentally retarded person lives out his life span with a minimum of stimulation or opportunity to use and expand his limited abilities.

In the affluent, industrially developed countries one of the greatest changes is the re-entry of the handicapped into the community - re-entry which encounters many difficulties.

In developing countries, where family ties are still strong, there has been greater reluctance to set up segregated facilities, not only for economic reasons, but because of the sound conviction that with a spirit of helpfulness and with adequate services for his special needs, the retarded person should go on living in his own village or town.

There is also another important development. A new model for the life and care of the disabled is growing, based on the idea that mental retardation is a dynamic condition, responsive to developmental approaches.

With regard to these new trends let me quote Dr. M.J. Thorburn (1977): "Since the Caribbean is a fairly virgin area as far as developmental disabilities are concerned, we felt that the most important concepts and practices to propagate would be the principle of normalisation and integration and its practical implications and applications. It was felt that if normalisation was established as a guiding principle, we could leapfrog from some of the costly developments which have taken place in developed countries, such as large institutions and heavy dependency on professionals."

From another part of the world community integration is stressed by H.E. Mansur Rashid Kikhia, Permanent Representative of Libya to the United Nations (1978): "My country envisages the following measures for the mentally retarded. First the establishment of day-care centres. These will facilitate the care, medical treatment and vocational training of the mentally retarded in their own neighbourhood."

If the community is to be involved, man's attitude to man must be modified; it also calls for increased public awareness and the combating of prejudice. This is an endless job. As the community accepts its new duties, manpower needs become increasingly evident. But how can we mobilise such manpower?

Who can act?

Assistance for the mentally handicapped persons may spring from many sources:

- Parents - as a result of personal experience and who are the most concerned with the problems of their children;

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Professionals - who bring their own skills and expertise;
Statutory authorities - who are accountable for improving the development and the welfare of the mentally handicapped person.

Who else should there be to tackle such a task? I can think of many other persons, old or young, powerful or powerless, rich or poor, influential or uninfluential ... we, you, the volunteers, motivated by a mysterious force which tends to defy analysis and is partly based on the need of man to find a purpose in his existence.

Definition

We must define what we mean by a volunteer and what we mean by a professional. A very simple division between the volunteer and the professional lies in the area of unpaid and paid work. Over recent years, however, it has been customary to describe voluntary workers as non-statutory, independent, offering alternative services. Both volunteers and professionals offer their services, skills and talent; it is obvious that the two complement each other; they are partners and as in every partnership, maintaining the equilibrium between partners is a most delicate task. When such a balance is achieved it is most advantageous for retarded persons. The same beneficial partnership exists on the international level between non-governmental organisations such as the International League of Societies for the Mentally Handicapped, of which the Caribbean Association on Mental Retardation is a member, and the International Labour Office, whose continuing and valuable support and assistance we, in the League, gratefully acknowledge.

Some questions

Who are the volunteers who work with the mentally handicapped? Where are they? What precisely is the help they can give? How do they communicate with mentally retarded children and adults? How do they co-ordinate their work with professionals? What is the action of volunteers with the extension of social welfare provisions? Is the participation of volunteers more emphasised in wealthy or deprived areas? What are the relations with trade unions?

Recruitment

Very often parents act as volunteers and point to the priorities, to the injustices, to the needs. I strongly believe in the dignity of self-help and therefore in the role of families of the handicapped. They should never abdicate.

In the past the classical movement was inspired and supported by people with an established position in their society. There is a decline in willingness among the younger generation to join this type of organism. A hallmark of today's voluntarism is that all strata of economic, educational and social levels tend to contribute.

It is worth noting that in many member associations of the League, 30 per cent are men and their numbers are steadily
increasing. A recent survey made in Switzerland showed that most volunteers are 25 to 45 years old. This is an interesting figure; the people in this age group are in the most productive and busiest years of their life; yet the people in this age group found time and energy to give. Gradually the participation of younger volunteers increases, with the extension of leisure time activities, pre-school programmes and recreation programmes for young adults. At the other end of the scale a very efficient programme of foster grandparents in the United States has increased the number of volunteers of an older generation.

When did they start?

Voluntary associations for the mentally retarded at the national level, as we know them today, are a phenomenon of the last quarter of a century. Small local associations started earlier as evidenced by a group of five mothers who met in 1933 in Ohio, USA, to express their indignation at the exclusion of their children from public schooling.

In 1946, in the United Kingdom, a mother again, published a letter in Nursery World: "I have resolved to form an association of parents of backward children".

In Switzerland in 1958, three parents met (for once this included a father) to start my local association in Geneva, which this year celebrated its twentieth anniversary. On the national level, the Intellectually Handicapped Children's Society of New Zealand is probably the oldest society of its kind.

Role of associations as political and pressure groups and in providing direct services

Volunteers, broadly speaking, work in two types of programmes:

(a) in public information programmes aimed at society in general, local and national authorities, legislators, politicians, etc.;

(b) in programmes which provide direct services or assistance to the individual mentally retarded person.

1. Volunteers as pressure groups

Political and legislative aspects

In these days, when the resources of a country are controlled by governments and when governments have undertaken in principle to provide social services, it has become apparent to many parents and volunteers that efforts should be concentrated by acting on governments. Is it a question of "political action"? Certainly, since governmental decisions always are, in short, political decisions. A few examples are provided.

1.1. The German Association, Lebenshilfe is very active in this field. Under the pressure of other volunteer organisations,
many new social laws have been adopted, others made more flexible or greatly improved (as in Israel); similarly in many European countries (for example in France - the "Loi 1975 d'Orientation en faveur des personnes handicapées"), in some Arab countries and in many other parts of the world.

The year 1968 marked an important step for the mentally handicapped of the world; in that year the International League of Societies for the Mentally Handicapped adopted at its fourth congress in Jerusalem, the Declaration of General and Special Rights of the Mentally Retarded, which had been prepared by a group of volunteers at a symposium in Stockholm, Sweden. This was the basis of the UN Declaration of Rights for the Mentally Handicapped. "Such declarations are, however, merely steps which lead nowhere if they are not followed by many subsequent steps, taken in the proper sequence and pace in the same direction" - writes Dr. E. Boggs, who chaired the International League's Task Group on Implementation of Rights. Member associations of the League have started a careful analysis of the extent to which the various rights are being applied in detail in their own countries; the main purpose is to see where changes and improvements are needed.

1.2. Progress in Pennsylvania, USA. In 1971, the Pennsylvania Association for Retarded Children brought a law suit against the State for its failure to provide them with a free public education. In a court decree, reached by consent agreement, the State Department of Education, acknowledged its responsibility to offer educational programmes for all mentally retarded children in the State, including those in institutions. The agreement affirmed that none should be rejected, that all are educable in some sense, if only in self-care.

1.3. Progress in Italy. Italy provides today a fascinating example of changing attitudes in the educational field through parents' pressure. The Italian Constitution guarantees the right for public education to all handicapped children. Neither the terms "special education" nor "separate education", are written anywhere in the Constitution. On the basis of these constitutional rights, parents and staff of one of the Italian provinces, a few years ago, required and obtained from the Ministry of Education, educational opportunities for handicapped children in normal schools. Under the new provisions, there is no move to set up special schools, or to start special classes in ordinary schools. Education for the handicapped child is in ordinary classes of the local school, with adequate supportive services. Who is then integrated? All handicapped children. No child may be excluded, neither physically nor mentally handicapped: integration is understood as one way of improving the quality of life both of the handicapped and the non-handicapped child.


2. Volunteer work in providing direct services

2.1. The objectives may be very diverse; operating a nursery school or a day centre, initiating a workshop, a hostel. Volunteer organisations become unavoidably engaged in fund raising. It has advantages because it encourages solidarity and if the issues for which funds are being raised are clearly brought out, it is a means of informing the public. There are some very well planned annual campaigns such as the Flowers of Hope campaign in Canada, with sale of garden seeds packaged in sheltered workshops; also the annual national House to House appeal in New Zealand which brings the problem of the handicapped to the notice of every family in the community.

Fund raising also has its drawbacks because it perpetuates the old idea of charity (i.e. once we have given a little money, we can forget the rest) whereas we now wish to emphasise the idea of the rights of the retarded person.

2.2. Inactivity in residential institutions is one of the major problems in the handicapped child's or adult's life.

Dr. A. Kushlick (1976) stresses that only very well organised programmes in the United Kingdom manage, at all times of the day, to engage more than 50 per cent of children in planned or even unplanned activities. In most programmes there are times of the day when 80 per cent or 90 per cent of children are literally doing nothing. It is evident that these children could find a kind of help that the interested individual, the concerned volunteer can give. The first duty rests on the authorities who must provide adequate personnel. Nevertheless, the best system, as the best cheese in the world, has holes and volunteers can provide a specific assistance to the retarded. Often we hear professional people, teachers, nurses say "I could do my professional job better if someone else could help me, in listening to him, in finding out how he feels, what he thinks".

For many handicapped children and adults, happiness is associated with a good professional and a kind volunteer.

2.3. Under voluntary auspices, two new programmes have started in the last decade in North America and in New Zealand in answer to the fundamental question of parents "what will happen to my child when I am no longer there?".

These are the Citizen Advocacy Schemes, in the USA and Canada and the Trustship Scheme in New Zealand, which assure a long-term protection of a handicapped person after his parents have died.

Volunteers are recruited to serve on a one-to-one basis as friends, spokesmen or guardians and the system relies upon volunteers and a paid office, which recruits, screens and follows the advocates.

Problems

There are untested, pessimistic speculations as to why professional and volunteer collaboration cannot take place. There
are no grounds for this if volunteers and professionals clearly understand their respective role and work together in mutual respect and mature relationship.

Some resistance may be due to "myths" which are perpetuated about the old image of the volunteer and his unreliability.

Voluntary bodies must ensure that volunteers are provided with good guidelines, organise, follow-up and assess the value of the service rendered. In Brazil, the Federação Nacional das APAEs in São Paulo offers a very efficient framework and training programme for its volunteers.

Recognition is necessary for the volunteers, in particular for young people. "We are not just nice people to have around." They are right. Young people as volunteers have many qualities. In a world where so many limits have been accepted, it is the person ignorant of past stigmas who is prepared to try something new. The young people are prepared to accept mentally retarded persons just as they find them, not persons to be frightened of or feel sorry for, but people, who, given a little encouragement, a little understanding and a little support, can do more for themselves than has ever been imagined.

Does the use of volunteers increase unemployment? No, but authorities should always clearly understand that volunteers are not cheap labour. In virtually every sphere in which the volunteer movements have an interest, it has been possible to witness a dramatic rise in the involvement of the State, and this means work. The first and most obvious example is that government and local authorities in many countries have now assumed responsibility for providing social services that were once provided and financed by voluntary efforts.

Clearly voluntary activity is not about gap-plugging but about individuals becoming involved in their own community and in the development of their own community.

**When should voluntary organisations step in?**
- When nothing is remotely likely to be done, when the interminable delay between planning (so easy to do) and execution (so hard to achieve) has proved disastrous. Then adopt the principle "if you want something done, do it yourself".

It is well-known that handicapped children need early stimulation and education and one cannot wait to set up pre-school education until the State makes it compulsory. Voluntary organisations have therefore in Spain, Italy and Switzerland started such schools on a volunteer basis.

- When it is perfectly clear that there is a major gap in provisions which for economic reasons has no possibility of being filled in the foreseeable future. However, even in doing this themselves, volunteers should enlist co-operation and support from all agencies who may be even remotely concerned. Such programmes have started in India, Tunisia and Hong Kong.
One of the major roles, where services exist is to act as "watch-dogs" (an excellent image given by W. Wolfensberger), in order to control the quality of these services and to act as agents of improvement.

It is interesting to note that it is in countries where the public services are highly developed, that in spite of the extent and quality of the services furnished by the State, volunteer associations have a good reputation and play an important role. Such is the situation in the Scandinavian countries. This situation is paradoxical only in appearance; in fact the State is aware of the amplitude of its own task, of the need for innovations and the roles which can be assigned to the volunteers. There is therefore a tendency towards co-operation at the highest echelon.

Twenty years ago, when the first association of parents and friends of the handicapped started in a few countries, none of us could have conceived of the sheer number of voluntary movements on behalf of the mentally handicapped that we now know to exist in the world. Let me just mention that the International League of Societies for the Mentally Handicapped had in 1976 already 82 member societies in 64 countries of the five continents. Even though their share and importance cannot equally be estimated everywhere, all of them contribute to help the mentally retarded person fulfil his role in society.

No matter how much government involvement in society increases, there will always be areas in which volunteers are needed. As society changes, so will new needs appear and volunteer movements will invariably have to take care of them.

The need for this type of personal responsibility and action is universal and we shall always find volunteers where there is a yearning for social justice which has to be considered as an extension of concern for the rights and happiness of individuals.

"I want to change things
I want to see things happen
I don't want just to talk about them"

A volunteer

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10. Training and employment of the mentally retarded in agriculture

by

Dr. Emanuel Chigier

1. Introduction

Many years ago, in the so-called "developed" countries of the Western World, a massive drift from the country into the cities developed, which is now also being manifest in the developing countries. At that time it was customary to arrange for the placement of retarded persons in large institutions out in the country and away from the city, so that they could "enjoy the quiet and healthy air of the country", and also be out of sight of the community. Many retarded persons were then employed in farming activities in a way which was not specifically rehabilitative in approach.

Today, there has been quite a reversal. Many urban dwellers make efforts to spend as much time as they can out in the country and away from the city, while the new approach towards the retarded is to take them out of the distant institutions (or prevent them being sent there) and have them placed in the community. Sometimes if the community is too small and not sufficiently urbanised, suggestions are made that the retarded person transfer to the big city where work in a specially designed workshop (i.e. sheltered) or in the open labour market may be available. The question arises therefore "Is there a place for training and employing retarded persons in agriculture and related activities today?". I believe there is.

2. Misconceptions

I think it would be appropriate to begin this analysis by dealing with three commonly held misconceptions about work for the retarded in agriculture.

Lack of (or diminishing) opportunities

It is true that in many western countries, less and less people work on the land, and that unemployment may be higher in rural areas. This does not necessarily mean that there are less opportunities for work. In Canada, for instance, despite a constant and high unemployment rate, farm workers are brought in from the Caribbean and elsewhere at times of seasonal urgency such as apple-picking. Directors of programmes for retarded workers in agriculture and horticulture that are well organised nearly always report that they cannot keep up with the demand for their services. Farmers who are ageing require supplementary work that is not provided any more by young children or adult offspring. A survey in three countries in Eastern Ontario (Cooke 1977) indicated that there were 233 farmers who had jobs for retarded and might hire them because they needed the extra help. Of these 135 favoured the concept of a supervised workteam - which fits in very well with my belief in the use of a small group approach (to be described later).
In countries where half or more of the population are in agriculture, the potential is even greater. Indeed, it sometimes seems somewhat inapplicable to set up a sheltered workshop on the American or European model in countries such as India or Guatemala for mentally retarded who are living outside the major cities.

The nature of agricultural work

When thinking about "farmers", three common associations come to mind:

(i) the "cowboy" riding his horse over vast lands and controlling huge herds;
(ii) the "tractorist" working with tractors, combines and other heavy machinery;
(iii) the "labourer" standing in manure in the cow-shed at 4 o'clock in the morning.

Type (i), and to a certain extent type (ii), are not thought of as suitable for retarded persons, while type (iii) is usually not attractive for anyone, including retarded persons and their families, in this day and age.

The reality is that today agriculture and related activities also include the following areas:

(1) controlled farming - dairy, chicken runs, incubators, orchards, vegetable areas;
(2) agro-mechanics - various machines that require upkeep and repair;
(3) agro-industries - storing, sorting, packaging, transporting products;
(4) horticulture - a satisfying occupation, offering variety and various levels of sophistication in work (Copus 1978);
(5) work in public gardens of the city and (state and national) parks;
(6) work in private gardens in suburban areas.

All these offer positive potential for employment for retarded persons.

The "reactionary" attitude of farmers

Country people have generally been regarded as less liberal than townfolk. However, the experience of integration of the Blacks into communities in the Deep South of the United States as compared to cities in the North and East does not seem to lend much support to the above conception.

In interviewing farmers in a rural community in Israel where retarded persons from an institution had been employed in citri-
culture for over a year and comparing results with a survey done before the retarded began to work in the orchards, it was found that while prejudicial attitudes remained as high as before, specifically the farmers were in favour of, and satisfied with, employing the retarded persons who had shown that they could do a good job (Chigier 1970). The concrete, pragmatic approach of a potential employer (Cooke 1977) can be utilised as an advantage, rather than as a disadvantage, for getting employment opportunities for the retarded person if we go about it the right way.

3. Advantages

Agricultural work offers many advantages:

(1) **Physical activity.** Due to overprotection or neglect, many retarded adolescents and adults are in very poor physical condition. Physical activity involved in agricultural work improves fitness, co-ordination, morale, and allows for group interaction.

(2) **A healthy environment.** "Fresh air and sunshine" are as good for retarded as for non-retarded persons.

(3) **A sense of the aesthetic.** Working with tender plants, colourful flowers, scenic landscapes, helps to cultivate a sense of the aesthetic.

(4) **Mobility.** The nature of the work allows, and often calls for, a good amount of moving around, which is generally advantageous.

(5) **Variety.** Agricultural work usually provides more diversity on a daily and seasonal basis than is the case with semi-skilled employment in the cities.

(6) **Outlet for aggression and hyperactivity.** Levels of aggressive or hyperactive behaviour which would be intolerable in a closed confined atmosphere of a workshop can be sustained, and perhaps subsequently modified, in an open-air setting.

(7) **Positive gratification.** Often the practical, concrete nature of the work may bring satisfaction. It is easier to see the fruits of one's labour in agricultural work than in routine work in many workshops.

(8) **Work demands.** In many cases, these are within the scope of the abilities of the retarded working by himself, under supervision, in a team, or as an assistant.

(9) **Speed is not a factor.** Productivity is not measured in short units of time, but over longer periods of days or seasons. This permits the retarded to work with less strain and allows other possible traits such as persistence, conscientiousness and caution to work to the advantage of the retarded worker.

(10) **Flexibility about work conditions.** Agricultural work is usually less unionised. Payment on a piece-work basis is therefore easier to organise, which is to the benefit of the retarded worker.
(11) **Minimal investment.** Training for agricultural work can be carried out after a short period of skills training and/or on the job itself through an apprenticeship or a team approach. It usually does not demand heavy investment in capital outlay, machinery, pre-vocational assessment, or a high ratio of staff to workers.

(12) **Opportunity for personal interaction.** The nature of agricultural work lends itself to the utilisation of a team approach, to the development of concepts of interdependence and co-operation which are basic to the growth of a retarded person as a human being. It provides an excellent laboratory for demonstrating the value of the utilisation of group dynamics with retarded persons, even those with moderate or severe retardation, and for studying and applying the peer concept.

4. **The peer group concept**

Most rehabilitation workers working with mentally retarded persons tend to make the same sort of mistake that the general public makes when reacting to the retarded. We tend to plan our management of the retarded according to the way they are, rather than to what they might be. We regard intelligence quotient as the upper limit of possible achievement, rather than to see it as the floor - the present functional ability of a person. And, worst of all, we tend to treat the retarded in a way that we think is good for him and good for society. We do not usually begin with the more important viewpoint - as to what are the needs of the retarded person himself or herself?

It should be emphasised that, like other people, one of the basic needs of a retarded person is the need to belong. A severely retarded person often has trouble belonging. In his own family he is usually out of step. Often they are ashamed of him. In the street, he does not belong. He has no natural affiliation to a peer group. In the institution - residential or ambulatory - he often has difficulty developing a sense of belonging, of pride and identity with the institution because of the size and nature of the institution, the attitude of the staff and the social implications of requiring to go to an institution.

Since most of us satisfy our need to belong through membership in small groups of people who are our peers, the object of my research over the past ten years has been to evaluate the efficacy of the use of a group approach in rehabilitation of the moderately to severely retarded.

5. **Research on a group approach in agriculture**

A research project was carried out from 1965 to 1968 in Israel through Akim - Israel Society for Rehabilitation of the Mentally Handicapped - and dealt with male retarded persons in a residential institution, sited in an agricultural area, about 30 minutes' drive outside Tel Aviv. The project was supported by Social and Rehabilitation Services, US Department of Health, Education and Welfare (Chigier 1970) (Research project No. VRA-ISR-23-65).
In applying the principles of group dynamics to severely retarded persons, the project first established four peer groups oriented toward becoming workgroups and using a group milieu approach. Each consisted of approximately ten members and had its own group instructor, experienced in working with youth. The chronological age of the retardates was 16-32 years, with an average of 20 years; the mental age, 3-8 years, with an average of 5 1/2 years. About one-third had an associated handicap such as mongolism, Down's Syndrome, cerebral palsy, or epilepsy. Three groups lived in an institution which was set up at a work colony. The retardates in the fourth group lived at home with their parents in an urban area.

Each group functioned as a group eight hours a day for five-and-a-half days a week. The first three months were devoted solely to consolidation of the group through games, walks, social activities, and an intensive programme of physical education. The next stage was a group project, such as setting up a rose garden - a tangible project with a clearly defined goal. In the third phase, the group worked outside the institution in citrus groves on a voluntary basis.

When the group had demonstrated its capabilities, work was obtained on a piece-work basis, with payment based on the productivity of the group as a whole. Fifty per cent went to the institution, 25 per cent to the group fund and 25 per cent to the individual members. Since there is a labour shortage in Israel, the groups were able to find enough work in various fields to keep them employed throughout the year.

Thus, within a period of eight or nine months, the role of the institution became that of a "rural hostel". Trainees were able to walk as a group from it to orange groves two or three miles away, allocate the work among themselves, stop for lunch in the grove, and return to the institution after a day's work - all with only nominal supervision by the instructor. The same ability was demonstrated by all four groups.

The basic principles of a group approach towards the employment of the mentally retarded in agriculture were the establishment of a peer group, the opportunity of the group instructor to have maximum responsibility for his own group and the creation of a "group milieu" covering a full workday.

Through the process of group dynamics, individuals working with the group experienced greater satisfaction, found effective means of coping with the crises and stresses of an open society and exhibited more mature behaviour - even though their cognitive abilities continued to be extremely limited.

Retarded persons, within the security of their own group, enjoyed the experience of working in the open agricultural labour market and were able to reach 30 to 40 per cent of the productivity of regular agriculture workers.

Opportunities for employment of retarded were better when applicants were considered as a group, the employer thus being relieved of responsibility for the individual. Where groups of retarded had been working for a year, follow-up studies indicated that although the farmer employers retained their negative attitude
toward the mentally retarded in general, two-thirds of them were willing to have a group of severely retarded males from the institution work in their area. They actually preferred retarded workers to the regular labour force because the retarded workers worked more slowly and carefully and thus damaged less fruit; only 7 per cent as opposed to 13 per cent. Since agricultural work is paid for on a piece-work basis, this represented a saving for the citrus farmer. He also benefited from their willingness to pick the oranges at the very top and the very bottom of the tree, which the regular pickers would not do because of the extra effort involved.

When the project ended, a group of about 17 trainees was set up to work in the orange groves while continuing to live at the institution. Nine years later (i.e. eleven years since the work began in the orange groves) they are still working with no difficulties whatsoever. They have become an accepted part of the labour force in the village and their productivity has increased with experience. It is of interest that several new members who did not participate in the research project joined the group and were successfully absorbed. Although further research needs to be done in this area, it appears that when a group is well-established and working regularly and smoothly the group, as a whole, together with the instructor, can act as a therapeutic medium for the training and rehabilitation of new members. The established group members become "auxiliary therapists", and help to modify the behaviour and increase the work motivation of newcomers.

Five members of the urban group, while still living at home, continue to work in the same park nursery where they were employed throughout the demonstration project. The director of the nursery supervises their work himself. They are paid on an individual basis by the city. All have shown improved behaviour and one has reached 80 per cent of the productivity of a trained regular worker. A sixth member, after making outstanding progress with the group, was accepted as worker in the parks of his home town. Without their continued and satisfying work in public gardens, it is more than likely that they or some of them would have been candidates for entry into institutions for a very long period of time and at considerable government expense.

Despite the long passage of time, both the agricultural and the horticultural groups are functioning satisfactorily and have become a satisfying way of work and life experience for the group members. (The movie "Ordinary work" describes this project.)

6. Other programmes

Let me now turn to some other positive examples.

One of the most expanding and stimulating developments in the utilisation of horticulture and the group milieu approach has been that at Belwood Training Center, Upper Marlboro, Maryland (Copus 1973, 1978) in the United States. Beginning in 1963, Belwood has developed to consist of four major physical facilities - Belwood Horticultural Center, Belwood Farm, Greenways Work Co-op and Residential Group Home. A National Council for Therapy and Rehabilitation in Horticulture was set up in 1973 and has a membership of over 700 individuals and organisational members representing the USA, Canada, England, New Zealand and the
Nationalist Republic of China. Over 50 per cent of its members are associated with programmes for retarded persons. Beginning with the belief that the horticultural environment offered many stimulating indoor and outdoor work training opportunities which would lead to employment, the basic philosophy at Melwood has developed towards the exploitation of the varied work environment to promote "optimum motivation for positive individual, peer and supervisory adjustment and change".

The various pre-work and vocational skills training areas are ideally structural for grouping trainees into crews of five or six individuals of both low and high levels of abilities. As a result, a total crew strength is stronger than each separate individual entity (Copus 1978).

At the Laurel Buff Center of the San Juan Unified School District, Sacramento, California, a workcrew approach is used to train the severely retarded. In one study, four to six boys were trained in such job areas as the clean-up of recreational facilities, lawn maintenance, weeding and trash removal. The program's success after four years indicates a potential alternative to the terminal sheltered workshop employment of severely retarded, and an area of expansion for a school vocational program (Copus 1978).

The Department of Special Education, Southern Illinois University, supervises an 18-week residential programme for mentally retarded males. After three weeks of skill evaluation, vocational adjustment training is provided in five different work situations for the next 15 weeks. Two areas of training are the University Green House, where standard greenhouse procedures such as mixing soil and potting plants are taught and the Illinois Fruit Growers Exchange, a fruit warehouse where skills include sorting and storing fruits and loading and unloading trucks. Work placement and follow-up are provided after the trainees complete the programme.

Since 1972, the Home of the Guiding Hands, a southern residential facility in Southern California, has included horticulture. Parents and friends raised the money to construct the greenhouse, potting sheds, plant shop. Professional horticulturists gave their services in planning and lawn and growth maintenance.

Whitten village in Clinton, South California, runs a programme based on co-operative efforts of a department of horticulture, a university agency, and the state agency for technical and comprehensive education. Since 1972, it has provided on-the-job training in a commercial atmosphere. The diverse programme includes greenhouse, nursery, landscape construction and maintenance. After training in a programme at De Witt State Employment Service, residents of Selingrove State School and Hospital, Pennsylvania, are employed as seasonal workers for the harvest of potatoes, tomatoes and apples. They are paid the same wages and treated in the same manner as other seasonal workers (Copus 1978).

Farm activities can also be used as an adjunct to vocational and social training for retarded persons living in an urban environment. We all know of nature vacation programmes in the summer for retarded persons living in the cities - and how enjoyable and successful they are - just as they usually are for non-retarded persons. But we usually regard this as "time off" or "time away" from our vocational rehabilitation programme.
In describing the work training programme in workshops for the mentally retarded in Oslo, Norway, Larsen (1978) emphasises that the staff policy is not to treat mentally retarded, but to meet them. The Oslo agency owns an old farm, and holds training camps, 10-15 times a year, each for a week or two. Participation is voluntary. There are nine trainees and two staff members. The trainees are responsible for taking care of the farm - the house, the flowers, the lawn, the vegetables, and most of the household. In their free time, they can do what they want. "We have learned a lot about the trainees at the farm which we could not have learned under other circumstances. We have also learned a lot from the trainees."

This programme has the aim of training the trainees to become secure socially, and to obtain self-confidence. The social security and self-confidence go hand in hand with ability to work (Larsen 1978).

Thus farm activities can be woven into an urban vocational rehabilitation programme, providing satisfaction, and at the same time providing training which will stand in good stead in the urban working situation.

Sometimes utilisation of the advantages in temporary work as a small group in an outdoor, natural setting may provide the "break-through" for retarded persons who continually fail at holding jobs in the community. For instance, 25 young retarded men at Austin State School, Texas, who had repeated job failures were organised in a ten-week programme in groups of five to work in the state park, under supervision of college seniors. The tasks given them included building foot bridges, developing nature trails, painting buildings, clearing underbrush. There were also many opportunities for "rap sessions". As a result 13 trainees left the institution for full-time jobs, while most of the others are looking around nearby communities for places to live, so that they can get started towards independence (Posner 1977).

7. Conclusion

I think it is fairly clear that agricultural and related activities have a place in the vocational rehabilitation of the retarded (whether mildly, moderately or severely retarded) both in the developed and the developing countries. Combining the advantages of work in natural outdoor settings, with the utilisation of a group milieu approach, has been shown to be successful on a long-term basis beyond all expectations. By drawing on the resources of experts in education, psychology, sociology, vocational training, agriculture and horticulture, dynamic, progressive, challenging and exciting programmes in the rehabilitation of retarded persons in agriculture and related activities can be drawn up and established in any country of the world, without major investment in capital, machinery or manpower.

What is called for is imagination, flexibility, market research and a system approach.

The potential is there. The challenge is clear. The rest is up to us.
References


11. **Outlets in normal employment for the retarded**

by

Dr. Emanuel Chigier

Introduction

Many years ago, retarded persons were lumped together with the mentally ill, and were treated in hospitals. This is still the case in some countries. However, most countries moved over to viewing the retarded from a welfare point of view as an "unfortunate" requiring support for himself and his family. It is only in the last 20 years or less that there has been a further move towards recognising the retarded person as one who is mentally disabled. When the retarded was regarded as "sick", treatment was medically oriented and supervised. When the retarded became a welfare object, treatment was to provide care and help for him and his family. Only when the retarded person became regarded as mentally disabled did treatment become one of rehabilitation with its emphasis on abilities rather than on disabilities, on work rather than activities, on productivity rather than on avoidance of disturbance or unhappiness. Even so, until less than ten years ago the retarded who were considered eligible for vocational rehabilitation programmes were those with mild retardation, minimal behaviour problems, in a certain age bracket, not in residential institutions, and without any other disabilities such as cerebral palsy, epilepsy, etc.

The moderate and severely retarded, those disturbed and those with other handicaps were "written off". Opportunities for them in some of the advanced countries and communities lay in participation in an "activity centre" or at best in a "sheltered workshop" with or without disabled with other forms of disability.

"Facts" about the severely retarded

For the moderately to severely retarded, the following aspects were considered to be "true":

1. they are trainable, but not educable;
2. they require special individual approaches;
3. they can only manage routine, repetitive simple mechanical tasks;
4. they enjoy doing routine, repetitive simple mechanical tasks;
5. they are incapable of establishing healthy inter-personal relationships, especially with a member of the opposite sex;
6. they are incapable of benefiting from participation in small groups;
7. they are incapable of being sufficiently responsible as to run their own home, be in a committee or take over any administrative duties.
Today, it has become clear that all the above-mentioned "facts" are wrong as far as many (but not all) severely retarded persons are concerned. Those items that are true pertain just as much to the mode of treatment that the retarded receive as to the fact that a moderate to severe level of retardation is present.

In many cases, we have constantly underestimated the potential of moderate and severely retarded persons. Through over-protection, neglect, development of institutionalism, over-medication, low expectancy levels and working of the self-fulfilling prophecy principle, these retarded have not been given an opportunity to indicate to us what their true potential is, until very recently.

The enunciation and application of the "normalisation principle" by Nirje of Sweden and Wolfensberger in the United States (1969), the demonstration of new ways to train retarded to carry out complex assembly tasks through task analysis, use of discrimination learning, differentiation between task difficulty and task complexity, etc. (Gold 1972 and 1975), the College for Living Programmes at Metro College in Denver, Colorado and elsewhere the "People First" movement in Oregon - all these developments and others have shown that the moderately and severely retarded are capable of more than we thought could be done by them.

The role of the sheltered workshop

Many thousands of retarded persons are to be found in sheltered workshops all over the world, yet it is still not clear what the function of the workshop is and what it should do for its retarded clients.

In an analysis of sheltered workshops as a method of approach to the normalisation principle, Lenning (1978) considers the following four questions of paramount importance:

1. Should the disabled person be required to adapt himself to the job and the training possibilities offered, or should the jobs and the training be adapted to his particular needs?

2. Shall we stress the importance of the retarded person attaining a measurable economic success or is it our function to stress his social integration?

3. Can we equate the sense of achievement attained by the disabled with the same values as viewed by those who are not disabled?

4. Should a workshop for the disabled and handicapped be nothing but a place to work, or should it be designed to provide not only for development of job skills but furthering a social, leisure and personal attainment level?

In practice, sheltered workshops have not clearly defined the two roles: (a) provision of sheltered work on a long-term basis, and (b) training of retarded for discharge from the sheltered workshop and placement in open employment.
Barriers to open employment

The barriers to open employment of the retarded include the following:

1. **Cognitive limitations** of the retarded person.

2. **Lack of work skills.**

3. **Behavioural limitations** of the retarded person. With good training and correct placement, cognitive and technical limitations can be overcome. Job failure, when it does occur, is usually the result of behavioural problems.

4. **Attitudes of the retarded.** As a result of repeated failures, inexperience, over-protection and negative attitudes of others in the community towards them, many retarded persons are insecure, unsure, frightened and have a poor self-image - resulting in difficulties in obtaining and maintaining a job in open employment.

5. **Attitudes of parents.** Parents may be ashamed of their retarded son or daughter, or may be over-protective. They may be concerned with possible physical and/or social dangers for the retarded in the open community, or they may find industrial work done by the retarded son or daughter to be socially demeaning, in terms of the prestige of the family in the community.

6. **Attitudes of employers.** Because of over-caution, ignorance, prejudice, financial or social reasons, employers may often be against employing retarded persons. In Israel a study of attitudes of employers towards employing the disabled showed that physically disabled who were veterans were most favoured, followed by work-accident disabled, and that the mentally disabled ranked very low in favourability, as compared to other forms of disability (Florian 1978). Also some employers will not employ retarded because they will not have the heart to fire him, if he is incapable.

7. **Attitudes of employees.** Other workers may make fun of the retarded, disregard him, avoid co-operation or social contacts in the work setting, feel threatened about their jobs when retarded are employed, or feel stigmatised by the feeling that the kind of work they do can be done by others with inferior cognitive abilities.

8. **Attitudes of unions.** Union officials similarly may create difficulties for employment of retarded, regarding their working as a threat or a stigma. Also, the requirements of a minimum wage, provision of social benefits for the retarded worker as part of the working force may act as a deterrent when employers are asked to hire the retarded.

9. **Attitudes of professionals.** There are still far too many professionals in medicine, education, rehabilitation, social work, behavioural sciences who consider severely retarded persons as being cognitively, emotionally or socially incapable of getting and holding a job in open employment.
Attitudes of sheltered workshop personnel. Although never actually spelt out clearly, administrators and/or supervisors in a sheltered workshop who depend on subcontracts for economic survival may be reluctant to lose the more productive retarded person, who is now ready for work in the open labour market.

Financial considerations. Apart from minimal wage requirements, social benefits, payments, other financial problems that may act as a deterrent include getting adequate accident insurance cover or the loss of diminution of a disability pension when the retarded begin to work and receive reasonable pay.

Basic principles of job training and placement

All the above-mentioned barriers have considerable force and concerted, sustained and well-planned efforts are required in order to overcome them. Time does not allow for any elaboration, but it should be stressed that they can be overcome, for the benefit of the retarded person, who can be successfully placed either in manufacturing or in service industries in the community.

The ILO outlines on principles of vocational rehabilitation are in general applicable to the mentally disabled (ILO, 1970). With regard to open employment of the severely retarded, I would like to mention the following points:

1. Assessment. So much time, energy, money and manpower has been spent on assessment of the retarded, that sometimes it seems as though it is an end in itself. I believe there is too much assessment at the expense of training, placement and follow-through efforts.

2. Training for skills. We have become more aware that specific job training and concentrating on specific skills is not sufficiently contributory to the rehabilitation process.

A national survey in 1976 of adult training centres in Britain dealing with moderate to severely retarded mentally handicapped showed that "employment success was very low (less than 5 per cent) despite reliable staff estimates that over 11 per cent of trainees could succeed in open employment and a further 25 per cent in sheltered employment if places were available".

Of those trainees successfully employed, only about one in three enter a job which is similar to anything they have experienced during training. The survey also revealed that little was known about the job interests of trainees (Whelan 1978).

3. Socio-behavioural training. This seems to be the Achilles heel in the vocational rehabilitation of the retarded. While many are aware that behavioural problems are the main cause of job failure, few workshops offer more than a superficial social training - "grooming, nice manners and how to behave at the interview with the prospective employer". I believe that utilisation of a group method offers an excellent opportunity for providing vital socio-behavioural training.
"Extra-aural activities". Many believe a workshop to be a workshop and nothing else. Others feel that the workshop acts as the focus of the life-environment of the severely retarded, and should therefore include social functions, sport, picnics, etc. My own belief is that what is needed is something between the two extremes.

Placement and follow-through. Placement and follow-through (Moody and Williams 1971) should be regarded as the "grande finale" of the rehabilitation process. In practice, it is often handled in a cursory, peremptory, ill-planned manner, with minimal long-term follow-through. If workshops or training centres received "royalties" for every month of satisfactory work in open employment of their graduates, perhaps the situation may improve. The importance of a well-trained placement worker has recently been emphasised (Usdane 1977).

Graduating into open employment

Despite the confusion of purposes and some of the weaknesses manifest in a sheltered workshop setting, a fair number of retarded persons graduate from the sheltered workshop and find gainful employment in the open labour, with success often poorly related to level of intelligence. Although the aim of a workshop in Oslo is not towards employment in open industry, 45 of the former trainees are employed in full-time jobs with normal wages (Larsen 1978).

In a project in Nagpur, India, of 204 clients, 23 per cent could be employed in the open market, and a similar percentage in sheltered workshops (Wankar 1978). In Denmark, 1,788 retarded persons were in 39 non-residential workshops. Of those discharged, 15 per cent worked in a normal workplace at a normal salary and 12.7 per cent in a normal workplace at reduced salary (Jorgensen 1978).

A survey of 251 clients registered at a workshop in Tel Aviv, Israel, with a mean IQ of 50, at least 41.4 per cent were employed in the open job market, for a mean period of employment of four years (Katz 1971).

Success in finding employment on an individual basis for retarded persons has been manifest therefore. However, the difficulties in training, placement and staying on at the job are often very great and call for investigations of possible alternative approaches. One alternative that I believe has great potential is group training in the sheltered workshop, with possible small group placement in the open job market, and I have been fortunate enough to have had the opportunity to do some research in that direction.

Group work with the retarded in industry

From 1973 until 1978, a research project sponsored by Rehabilitation Services Administration of the US Department of Health, Education and Welfare, has been carried out by the Israel Society for Rehabilitation of the Disabled, with the co-operation of the Tel
Aviv branch of Akim. This research project is a study of the effect of a group approach on the behaviour and productivity of mentally retarded adolescents and youth in a sheltered workshop and in open employment.

The specific aims of the project were:

(a) to ascertain the applicability of a group approach to retardates in sheltered workshops;

(b) to investigate the stages of group formation amongst severely mentally retarded adolescents and young adults;

(c) to measure the effect of group technique on the productivity of trainees in a sheltered workshop;

(d) to ascertain the effect of a group technique on the behaviour of trainees in a sheltered workshop;

(e) to investigate the possibility of group placement in open industry;

(f) to derive conclusions and present practical recommendations on the use of a group technique for the rehabilitation of the mentally handicapped workshops.

In the first phase to the project, 13 male trainees were selected to be in the experimental population and 13 others matched for age, IQ, family background, were chosen to be in the control population.

Mean IQ was 50 (range 44-65) and mean age was 20 years.

The average length of time working in the sheltered workshop was four years and two months, and for the control population three years and two months.

After psychological testing and at the end of a baseline period of four weeks, one instructor's group was designated to be the experimental group and the other the control group. Both instructors were informed that it was up to them to demonstrate which method would show better results in productivity, i.e. the individual or the group method. If anything the instructor working with the control group and using the individual method was more enthusiastic about the individual approach than the instructor working with the experimental group was about the group approach. Measurements of productivity, work behaviour and behaviour pattern were continued as beforehand. In order to stimulate greater productivity, the instructor working with the control group posted figures on individual output next to the work area of each of her trainees for each week.

The work with the experimental group was carried out in a "low profile" manner, and in the following way.

Trainees remained at their regular work areas within the workshop. They were informed that from now on their work was to be

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1 Project 19-P.58073-P-01.
together, on a collective basis, and that productivity would be scored for the group as a whole on a weekly basis. The instructor was under close supervision and in close contact with the research assistant. The group met as a group every day usually at the end of the workday for a period of about 15 minutes to discuss the progress of the group. These meetings were eagerly anticipated, were very lively and turned out to be a great success. A weekly chart showed the rating of the group on productivity for the work on a five-point range from excellent to poor. At the end of the month trainees were paid almost equally with a slight difference in payment between "good" and "average" workers. The group tended to go together to the dining room for snacks and for lunch, sitting together in the dining room at the Centre. The experimental group was set up for a period of one year - and data was obtained from each population on work behaviour, general behaviour and productivity of trainees in both populations.

At the end of the experimental period findings were as follows:

(1) trainees in the experimental population showed improved behaviour in terms of less aggression (active or passive aggression), less withdrawal, and greater pro-social behaviour. The Director of the Centre, the group instructor and other personnel who had contacts with the trainees were definitely impressed by the better behaviour, greater alertness and improved emotional attitude of the trainees in the experimental population as compared to the control population;

(2) despite time taken off for group meetings, and discussion during the working day, productivity of the experimental population was greater than that of the control population.

It was concluded that a group approach is feasible in a sheltered workshop, can be carried out without disruptions, and can provide a medium for better behaviour, self-satisfaction and productivity on the part of retarded working in a group setting.

In the second phase of the project, five trainees from the original experimental group were placed as a group in open industry in April 1975. They work in a plant making tubes, which has 180 employees. For the first month, they worked under the supervision of their group instructor. But after one month it was possible to withdraw the group instructor, and they are under direct supervision of the foreman in the factory. Initially they worked together as a group, but now they are working mostly individually or with other workers. One worker has left because of opposition of his grandparents who are his legal guardians. The sense of belonging is maintained through the loose small group structure, while at the same time they are integrated into the plant, and they have numerous work and social contacts during the day with other workers - male and female. Their work is satisfactory, they come on time, are generally conscientious, have had no accidents and there have been no difficulties in relations between them and others. This is because group placement was done carefully with adequate preparation of management and staff, the presence of a group instructor for the first month and intensive follow-through contacts maintained all the time. Productivity is satisfactory, with productivity almost that of a regular industrial worker, and full social benefits have been provided.
Group placement as a small group allows for management to incorporate the retarded, with the presence of an instructor who guides the retarded during initial adjustment period and acts as a "buffer" between management and the retarded employees, until management gets to know them better and gains enough confidence to handle them directly.¹

Another method of utilising the group approach in service industries is the setting up of a "work crew" of retarded persons under the supervision of an instructor, who are employed successfully in short-term projects such as setting up prefabricated store-rooms and greenhouses (Bilowsky, 1978).

It can be said that utilisation of a group approach in rehabilitation of the retarded in industry is consistent with some of the current thinking about reorganisation of the work system in general so as to take into account the psycho-social needs of workers and thus diminish the "mindless" individual work done on an assembly-line basis (Emery, 1977).

Conclusions

In assessing the opportunities of the retarded person to obtain employment in industry, which is to the satisfaction both of the employee and the employer, I would consider the following points to be of note:

(1) less concern with IQ and more attention to personality factors;
(2) less attention to assessment and specific job training and more attention to psycho-social training, placement and long-term follow-through;
(3) less emphasis on the individualistic approach and greater development of group techniques and utilisation of group dynamics.

If we truly believe that the place of the retarded person is not outside the community but "amongst us", one of the major ways to ensure that this will come about and be maintained is by taking a fresh and optimistic look at the employment possibilities for retarded in the community and plan ahead, with full awareness of the changing needs of the work market, the employer, the retarded and the community.

¹ The project is described in the movie "Group Work by the Retarded in Israel".
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Assessment of mental capacity: some issues and some methods

by

Dr. M.J. Thorburn

In 1971 I had the honour of attending a three-week research seminar on vocational rehabilitation of the mentally retarded in the United States, organised by the American Association on Mental Deficiency and sponsored by the Social and Rehabilitation Service of the United States. Several of the speakers at this Seminar participated in that one and it was my first direct exposure to the field of vocational rehabilitation for the mentally retarded (MR).

Among the interesting presentations made including those by Drs. Whelan and Chigier, two features relating to assessment procedures for the MR struck me. One of these was that the IQ was an unreliable means of predicting success in vocational rehabilitation, and the second was that the most successful long-term placements of MR persons were those carried out by vocational rehabilitation service personnel as opposed to placements undertaken by school or workshop personnel. Both these conclusions came from studies conducted in the US and I think they are relevant to us at this time.

However, since assessment is the main topic to be discussed here I am going to concentrate on this area, though I would like us to bear in mind the goal for the rehabilitation process is successful long-term placement in jobs. So the question of who does the assessment is also as important as what kind of assessment is performed.

At the time when I attended this seminar I was a novice in mental retardation. Dr. Robert Gray (a paediatrician) and I had, one year previously, commenced a small assessment clinic for mentally retarded children. One of our major problems was, and still is to a lesser extent now, how to assess the children that we saw. The diagnosis of moderate and severe MR was no problem because it was obvious from the development and physical features that they were MR. We also found that the Denver Developmental Screening Test was a helpful simple tool to determine the level and degree of MR. However, we came to a stumbling block with the mild MR or border-line cases. When we sent these children to psychologists for IQs, we got back a number, perhaps 57, or 64 or 70 and the comment or conclusion "therefore the child is probably mentally retarded" but unfortunately this result gave us no assistance. What was to be done with this child?

Should he remain in the regular school where he already was and not doing well? Should he be sent to a special school? This would tend to label him and perhaps cause him to be at a disadvantage when he did not need the kind of programme that was being provided in special schools. The next question is what sort of teaching does this child really require?

Clearly, what was necessary was a set of criteria by which we could decide whether or not a person belonged to a particular group or not. When less placements were available for such groups and
criteria clearly defined by the facilities providing these placements, we were not going to be particularly helpful to the child by simply giving him a label of MR and after that being able to do nothing to help him.

It seemed therefore that what was necessary was that schools for special education had to more clearly define their programmes and then set criteria for entry into those programmes. We as assessors would then be in a position to help to decide whether or not the child that we were seeing fitted the minimum basic necessities of those programmes. Another question then came up of course - should it be doctors who decide whether or not a child attends a particular type school or programme?

The answer to this question clearly is - not necessarily. Other persons such as teachers are probably better able to assess and decide (as long as they know the criteria); this is not to say that a medical examination is not necessary at some stage since I firmly believe this is necessary. There may be a medical condition that needs treating. But for some reason or other it has been traditional for doctors to have their prerogative of deciding whether or not a person is fit for a particular type of school programme. In the United States it is even necessary for a child sometimes to be certified that he is handicapped before he can benefit from a particular programme.

Goals of rehabilitation

I have dwelt in some detail on this issue because it illustrates something that I have learned by experience, dabbling as I have as an amateur in what is thought to be a highly professionalised field fit only for psychologists, etc. That "something" is: before you can decide on what assessments you need you must first decide what is to be your end product. In other words, what is your goal for the rehabilitated person? Or the rehabilitation process.

Once you have decided on your goal you can then define it in operational terms by descriptions that can be used by everybody working with that person: what I am speaking about is measurable competences or skills.

Once you have clearly defined this long-term goal you can then trace a process, which in the case of the MR person is one that begins at birth or in early childhood and ends, or at least for this purpose ends in early adulthood. Because of this long period and the considerable changes and varieties of developments that occur during this period, it will be necessary to break the process down into defined interim periods with interim objectives. This is of course, done with the normal person during the early years by breaking down the periods into pre-school, school, high school, etc.

Because of the degrees and varieties of MR and the varying backgrounds from which people come, the expectations you might have for some may not be feasible or rational for others. So without creating the self-fulfilling prophecy of being unable to achieve certain levels simply by virtue of being MR (which is one of the drawbacks of using the IQ as a form of assessment) we must also be reasonable in our expectations or we will only create frustration and
disappointment for ourselves and our clients. We therefore may have to create alternative goals but always remembering we should be striving towards the highest goal.

I would now like us to consider the following questions:

(1) What is the highest goal for the MR person?

(2) Describe in simple terms, skills that an MR person must have to achieve that goal.

My response for question (1) is a person who is totally independent, who is able to earn his or her own living, support himself and perhaps a family in his own community and have a happy, productive and respected place in the society.

The second answer would be that the skills that a person must have to reach this goal can be classified in several categories:

(a) **vocational** - ability to do a job and earn money;

(b) **independence** - social and self-help skills which allow one to plan use of money, use public transport, plan, purchase and prepare one's own meals, secure a suitable accommodation and maintain it, look after one's own health, make necessary arrangements or contact appropriate people in cases of emergency;

(c) **behavioural skills** - these are abilities to get on with other people at work, at home and in the community to maintain acceptable behaviour patterns and not to have the negative behaviours that stigmatise a person as being MR;

(d) **communication** - ability to communicate with other people and the outside world both in terms of receiving communication and being able to respond.

(e) **mobility** - abilities to be able to move around and enlarge one's environment, experience and frame of reference and perform tasks of daily living;

(f) **academic** - I put this last because it is possible and in fact actually happens, to live life fairly successfully in a completely illiterate and unschooled state but this is becoming more and more undesirable.

In order to be able to reach these goals of maturity in independence, training and experience will be required.

**How, when?**

Our next question should be - when should a person be expected to reach the above level of maturity and independence? The answer to this is more difficult since it varies somewhat in different cases, but probably somewhere between the ages of 18 and 25 or 30. We have to recognise that the MR person although he may plateau off in his development at an early age - it is said - he still may have a lot of experience to be gained during the early adult years. Therefore we should not give up at the age of 18 or 20. This
independence and maturity will also need to be achieved in stages, therefore how should we stage these steps and who will be responsible for providing the necessary training and where? The latter is another issue and not the subject of this paper so we do not need to consider it further at this time.

Our next task here then is to define assessment tools that will measure the competences needed at the various stages in development. Standard developmental stages are usually as follows:

- from birth to six years - the pre-school period (this should probably be divided into at least two or three areas);
- 6 to 12 years - primary school period;
- 12 to 18 years - secondary school period;
- 18 to 22 or 25 years - tertiary period.

Obviously the pre-school and school years are very important and in the case of the MR person, academic skills may be very limited. More efforts should therefore be devoted to social, self-help and behavioural skills than would normally be provided for the normal person. Specific training strategies towards achievement of life and survival skills are absolutely vital for the MR person to live a life in the community.

Criteria and skills assessment

Since we are dealing with the adult and our subject is vocational rehabilitation, our main concern should be the assessment of the adult when he leaves his school, to set criteria for entry into adult programmes of various kinds and to devise appropriate training strategies for those who do not meet entry criteria to bring them up to standard. Finally, we must set reliable, realistic and appropriate criteria for achievement in various vocational training programmes provided.

Having set criteria and devised our assessment tools we should make this information available to schools from where we recruit trainees into VR so that they know just what standards are required for preparing their students. So just as the primary school teacher knows the standards of the common entrance and a specific syllabus is provided, and the secondary school teacher the GCE examination standards, so the special education teacher needs to know the objectives and standards for his/her students. However, these criteria or tests must not be so cut and dried that anyone who does not make the grade gets dropped out. They should allow for the identification of weaknesses and strengths so that special training can be given to correct the deficiencies.

This brings me now to the next subject.

Purposes and types of assessment

There are four main purposes of assessment in my view, all of which have their place. I would like to outline each one of these. They include:
screening,

placement,

prescription,

prediction.

Screening tests - these are tests which have the following characteristics: cheapness, easy and simply administered by a non-professional person and a reliable and valid indicator of more serious problems. A screening test may also indicate the presence of a condition before the overt symptoms of that condition have appeared. The main purpose of the screening test is to quickly determine whether a person has or not sufficient certain critical characteristics that mark him out as needing further investigation or has a potentially serious condition which will require more extensive investigation and treatment. Simple examples are the urine test for diabetes, the Papanicolaou smear for cancer of the cervix, and hearing and DDST tests for deafness and developmental disabilities.

Tests for placement - these are really criteria which have been set to determine whether or not an individual has most if not all the features which characterise a group of persons who are given a certain type of programme or therapy. For example, children with no speech might belong to one of several groups whose treatment needs may be quite different, e.g. hearing impaired, learning disabled, mental retardation or simple developmental delays. The test is designed to pick out the important features of these groups so that the person can be more accurately and profitably placed within a group. It may also have certain criteria which may exclude some persons from certain groups if they have not reached a certain level. For example, children may not be taken into special education programmes if they are not fully toilet trained or ambulant.

Prescriptive tests are those that determine factors on which a prescription for training or therapy can be provided or devised. The characteristics or competences determined this way are usually identified by observation of actual behaviour or reported behaviour of the client and therefore can be verified by other people and modified and developed by training procedures. These tests are usually more detailed and take longer to do. However, they do facilitate training of individuals by utilising people who have less sophisticated levels of training. We have utilised this approach very effectively in our early stimulation project using the Portage curriculum for developmental skills. These tests are very detailed and take longer to do.

It will be clear that these three types of tests are really part of a hierarchy of increasingly complex and long tests from screening to prescriptive. Quite often also, screening and placement tests represent the most important or valid features of the prescriptive tests. Time and effort is saved by undertaking the simpler ones first and using less highly trained personnel and thus excluding the need for complex tests in some cases and saving time of more highly specialised persons.
I would now like each person to list 8 or 10 skills that can be observed and verified that a person would need to have by the age of 16 or 20 years which would enable him or her to enter an unskilled job or to be trained in some type of occupational skill. We will then study the global assessment scale which we have been using in the programme of the JCH for some two years. This is a modification of a test obtained in the United States from Luke Watson. Of course it is not the only assessment tool that can be used since it does not provide information on a number of areas including medical aspects, academic achievements, vocational interests and aptitudes. All these aspects need to be included in a total assessment. For example, if a candidate is to be accepted in an office training centre, academic skills will be more important and it will be necessary to add such a test to the battery of assessments.

I make particular mention of medical assessment at this point because I think it is vital that any medically corrected condition should be dealt with before vocational rehabilitation or training is undertaken. If this is not done, valuable time may be wasted dealing with something which is medically correctable. Some of the other kinds of assessments that can be performed for MR persons will be discussed by other speakers.

The global assessment scale is a fairly detailed tool but it can be carried out by people with little professional training and provides a very broad spectrum in terms of a picture of the person's competences and skills in seven different areas. What needs to be done with this scale is that from it one can determine essential criteria for entry into various components of programmes available. This needs to be done in Jamaica right now since we have not really critically developed these criteria. We recognise that the MR person will probably need more pre-vocational training based on the presence or absence of skills identified in this assessment to bring him up to a level whereby he can occupy places in training courses which are made available for other groups of persons including other handicapped and perhaps normal people. At the present time it is not possible for us to say exactly what proportion of MR persons have what kinds of skills but we hope to be able to do an analysis of this during the next few months. From this we should be able to determine what areas the MR person is inclined to be most weak and then we will be in a position to design pre-vocational training programmes to assist this group of MR persons.

(4) **Predictive tests** - I am not saying anything on this topic because I am not competent to do so. IQ tests have been used for this purpose in the past but have not been found to be particularly helpful. Probably some of the other speakers here can speak more knowledgeable than I on this topic.

**Summary and conclusion**

My main thesis has been that assessment of capability of the mentally retarded person (or any other for that matter) should be on the basis of the presence or absence of competences and skills known to be essential or helpful in allowing such a person to participate in or benefit from training, rehabilitation or employment programmes.
As Drs. Durand and Neufeldt pointed out in their excellent document "Vocational service systems", the mentally retarded population is not homogeneous, it is heterogeneous like any other population, with varying levels of competency so there will be variable needs in all the important areas of development. It is these that should determine what kinds of assistance, if any, the person will need. There should therefore be a graded series of options that provide opportunities for people with different levels of competence, always striving to achieve the highest option which is independence and integrated work.

The last point I would like to make and I do not think this is one that we have mentioned before, but all assessments should lead to individual programme plans for whatever type of training or therapy is required. No assessment should be done which brings a question "so what?" which cannot be answered.
13. Employment development centres

by

Dr. George Soloyanis

I have changed the title of my assignment to reflect my belief that sheltered employment should never be discussed apart from a general context of activities appropriate and necessary for retarded people. I prefer to deal with "the role of employment" or "economic activities" for retarded people, under which sheltered employment or accommodated employment or sheltered workshops may have a prominent role. I am trying to avoid reinforcing stereotyped thinking which suggests that the best and most comprehensive programme for retarded persons consists primarily of special education or training, then placement into a sheltered workshop.

I am assuming that your concerns are for all of the retarded people in your country, not just for the ones you happen to see or know. An easy assumption is that your resources are limited and that you wish the highest, the most long lasting, the most stable benefit for the most.

Therefore, in order to assist you with your planning, I have identified 24 economic activities suitable for retarded persons, and which are now being undertaken somewhere in the world, and not necessarily in the industrialised world. Dr. Molly Thorburn, Dr. Neufeldt, Mr. Leslie, Mrs. Brown, Dr. Chigier and others have alluded to some of these activities elsewhere on your programme.

I identify so many models in order to demonstrate that there is no one preferred way, that you cannot really copy someone else's way, and in order to begin to show how important to the employment models you may choose, your unique socio-cultural, political, and economic environment is, and to suggest that many times the highest benefits to mentally retarded persons will result from efforts to modify those environments, rather than from efforts to provide direct services yourself. My second motive is to stimulate you to add still other types of economic activities to the list presented here today.

Although we can trace, at least in the United States, the origins of special or sheltered employment for handicapped people back 130 years (which began with the blind), it is only within the last approximately 10 years that the population of mentally retarded persons has entered into any kind of significant employment. It has been very difficult to overcome the many, many barriers that societies have erected against this category of handicapped and it was even harder to dismantle the many barriers, mechanisms and institutions which impeded access to the relatively free world for the mentally retarded. Many, many factors came into play. The retarded person is living longer and something has to be done with him over a longer period of time. There has, to some extent, arisen a disgust with long-term institutionalisation as a final solution for retarded persons for many reasons which the scope of our meeting cannot cover. There has been a spectacular growth of special education resources and programmes. We have seen the arousal of national political and social sensitivities. We have seen especially the growth of the rights movements and probably best of
all we have seen success in programming. We know that retarded persons can learn, we know that they can work, and we know that many of them, if they are not damaged by our systems of help, can lead very close to independent lives. We know that they can generally equal the activities of other handicapped groups, given proper support, shelter or accommodation.

For those of us here who are professionals or leaders, it should be obvious that before selecting a particular series of economic activities to promote for the mentally retarded, that we gain a thorough understanding of the total national social system in which we wish to establish better things for the handicapped. We must understand the economic and manpower systems, such matters as the infrastructure concerned with vocational training, special education, job placement efforts, employment prospects, rates of economic growth, and the directions of economic growth, and so on. Above all we must know the political process, and obtain access to it.

It does not matter that some of these things are unfamiliar to some of us, or that we may not know how to proceed at this time. In our zeal and dedication to the provision of concrete direct services to some handicapped, many of us ignore paying attention to the political aspects of our leadership.

For example, many of us have visited workshops and other rehabilitation programmes, or we may have read extensively, or some very expert practitioners may have visited with us, and they showed us how to do something. Under such circumstances, without any other consideration, it seems that we have only to choose a model of services that we like, or that everybody says we should have, or that seems feasible, and then figure out a way to pay for it. When we do this, most frequently we succeed in establishing a "charitable enclave", usually very small, very limited, with a static population. Certainly things can be copied by groups of determined leaders but without a consideration of the political and cultural context, such copies remain imports, and they always need artificial respiration.

Let us now consider 24 ways of providing economic opportunities for mentally retarded persons which are now being used somewhere in the world. Firstly, several presenters have offered us this week examples of research which establish that the mentally retarded can learn to work, and that subsequently they do work. Actually, in the large institutional care system of many US jurisdictions, now thankfully being re-evaluated and phased down, the mentally retarded have always worked. They have worked for 200 years under systems designed to exploit their skills and labour. They have been farmers, electricians, carpenters, plumbers, laundry and kitchen workers, cleavers, feeders, nurses' aids. Institutional systems had their own factories manned by the mentally retarded, making furniture and clothing. One institution was famous for its county fair prize cattle, reared by the retarded.

Long ago, self-contained institutions were established in the countryside. They were to be self-supporting islands of benevolence. Although the work of the retarded provided significant economic support to these institutions, resulting in considerable savings to the State, finally we saw a system of peonage, where instead of rehabilitation and release, we had a programme of life-
long unpaid servitude. Fortunately, this immoral system is now ended. Therefore we do not need research to prove that the mentally retarded can work; they have always learned to work whenever we have needed them. Their working ability should not be the question, rather the research emphasis may yield significant value if concerned with how to get the mentally retarded to the work that is there in the community.

1. **Free labour market status**

Here we expect to take a mentally retarded person, train him in some occupation which is in demand, then we expect him to apply for a job and be employable on his own merits. There may be some additional help needed, just as we might provide for any other young adult, such as job counselling, help in learning where the jobs are, and the usual matters attendant to a successful application. The free labour market status is usually at the top of any hierarchy of outcomes which we have considered to be most desirable.

Considerations or actions:

(a) Does the national vocational training system or other system accept or accommodate mentally retarded persons so that they can acquire marketable skills?

(b) What employer attitudes may need changing - what community bias must be worked on?

(c) Is there a pool of trained retarded persons available for immediate employment?

(d) Do you believe they can make it in open employment?

2. **Free market labour status**

plus additional support

Some otherwise well-trained retarded persons may have difficulty getting to the place of work, others may need supportive counselling from time to time, still others may need protected or special housing arrangements. Basically, we expect persons in this status to go to work but to use these special support services so long as they are necessary.

Considerations or actions:

(a) Which is more reasonable or economical, to transport five persons to and from their jobs, or to put them into a sheltered workshop?

(b) Is there a group home or a foster home or a boarding home that can be made available?

3. **Selective placement**

This is a well-practised procedure where a placement officer or rehabilitation counsellor finds jobs that they know a retarded person can do, already existing jobs. The task of the counsellor is
to point this out to the employer and to assist the employer in the hiring of the retarded person. Selective placement is something that we do in order to find that special or right kind of job for our people.

Considerations or actions:

(a) Are the national or business placement agencies practising selective placement?

(b) What can your agency do to improve the situation?

4. **Selective placement plus accommodation**

Sometimes, in addition to finding the right job for the right person, we may have to modify the job to make it more right. Obviously, such a process implies at least a willingness on the part of prospective employers to experiment.

Job modification or accommodation has been used extensively for physically handicapped workers, and for retarded persons. A job may be structured in a way that makes it difficult for a retarded person to produce, and the task is to assist the employer in modifying the job without unnecessary loss in productivity, without increasing the cost unreasonably so that the handicapped person can apply himself.

Some accommodations that may be made are job-sharing, where two persons share one job, or flexitime, or part-time work, and so on.

5. **Self-employment**

A handicapped person qualifying for self-employment must not only have the necessary career skills but must also be equipped with at least rudimentary social and business skills. Such additional training should be part of vocational training programmes when such candidates are identified. Consideration should be given to technical follow-up services by the training centre, as well as the provision of a small loan fund to get such enterprises started.

6. **Enclaves, public or private**

In an enclave, an employer will usually set aside a place within his establishment and may or may not especially equip it for the productive efforts of the mentally retarded person. Usually one might need some additional supervision which may or may not be supplied by the rehabilitation centre. It has the advantage of placing the retarded person in a realistic production-oriented facility, and affording him the extra stimulation which is available. Clearly, much negotiation with prospective employers is necessary.

Considerations or actions:

(a) Is it better to provide the workshop in someone else's place, giving only supervision?
(b) What will it take to persuade some enterprise to try it?

7. **Work crew**

A work crew may work in an enclave, or move from job to job, usually providing a service. What is sold is the output of the crew, not that of any individual member. Usually has an able supervisor provided by the rehabilitation centre, which also provides tools, supplies, transportation, etc. Work can be anything that a group can be trained to do.

The advantages are that even minimally productive workers can be used and perhaps stimulated, it provides changing environments, co-operation can be learned, and the need for buildings and fixed equipment can be minimised.

Considerations or actions:

(a) What kind of economic opportunities exist for such work crews, and can we compete for the work?

(b) Who will organise it?

8. **Subsidised on-the-job training**

OJT is a method used to prepare handicapped persons, such as the mentally retarded, for specific jobs with a specific employer, agency, business, or other. The rehabilitation centre may subsidise through the payment of training wages and other costs, the training of mentally retarded persons in actual industry, agency, or corporation jobs. The potential employer usually contributes space, machinery, overhead costs, etc.

In addition to receiving realistic training and tryouts, trainees are able to demonstrate to the co-operating employer their ability as an economic potential to the enterprise. Furthermore, at the point of hiring, trainees are better trained than general job applicants. We do expect graduates of OJT programmes to be ultimately employed at the training facility.

Other advantages are the elimination of costly investment by the rehabilitation facility in training equipment, the elimination of a general job search for their trainees, and the additional resources provided by co-operating agencies.

Considerations or actions:

(a) Are there industries, businesses, farms, or other large employers who can be approached?

9. **Workshops without walls**

Here we have a work situation where the jobs or job stations are in community agencies, industries and businesses. With the work stations in realistic settings, the transition to a real job is made much easier.
Industries or businesses agree to provide settings for training. A general evaluation and work adjustment can take place in the workshop, thereafter specific job skill training, later job placement and tryout, employment and follow-up.

In a workshop, sheltered or otherwise, which admits mentally retarded persons with some potential for good productive work, WWW eliminates the need for costly training equipment and machinery, and for further capital investment in large buildings. Instead funds are invested in developing the job stations outside, and in necessary supervision.

Considerations or actions:

(a) How many retarded persons are employed by your agency - or are being trained in real life jobs stations?

10. Projects with industry

The manner in which Goodwill Industries is handling these projects should be of interest. Once a project is planned and announced, a community governing committee is formed made up of the top employer executives in that community. They, the employers, advise the workshop about the jobs in the community, what training is needed, what changes are taking place, etc. Eventually they form smaller committees to plan the training for their own industries. These voluntary committees are given staff support by the local workshop. Wasteful training, i.e. for obsolete jobs, is eliminated, and valuable employer contacts are maintained. The potential employer becomes directly involved with handicapped persons, and his administrative and executive experience can be tapped.

11. Co-operatives

Certainly co-operatives are a long-established system of mutual benefit for their members. In economies of high unemployment, they may furnish the best available economic organisation for the handicapped. There are many instances of handicapped persons, admittedly mostly physically handicapped, who have formed themselves into co-operatives for the purpose of conducting economic activities.

I believe that co-operatives are especially adaptable to mixed groups of handicapped people, accommodating the blind, the deaf, physically handicapped and mentally impaired, allowing the strengths of some to compensate for the lacks of others.

It may require much planning to get a compatible mix, and the training must include many organisational and business skills.

Considerations or actions:

(a) Are there any co-operatives in your country whose experience can be studied?
12. **Preco-operatives**

In some Latin American countries, especially Colombia, they are experimenting with several groups of preco-operatives. Some rehabilitation leaders feel that it takes a great deal of time to establish a true independent co-operative, and for many severely handicapped persons, a long training or trial period will be necessary. Preco-operatives will have a master or patron or non-handicapped leader who sets about the task of establishing the co-operative, taking as much as five years. The preco-operative naturally begins to engage in economic activity as soon as possible and one expects the economic subsidy it receives to diminish over time. For both co-operatives and preco-operatives, additional living and social skills will have to be imparted to candidates.

13. **Quota system**

A number of European countries have enacted legislation mandating that private industry hire 1 per cent or 5 per cent or some percentage of handicapped persons, including the mentally retarded. It becomes the responsibility of the rehabilitation leaders to provide appropriately trained and ready handicapped people. Most observers comment that this system has not worked too well, that employers prefer to pay the penalty, and that enforcement of the laws is practically non-existent. Although quota systems are currently not in favour in highly developed countries, might they succeed elsewhere?

14. **Social employment**

In times of economic distress, or to favour a privileged group, or to carry out a national social goal, governments have been known to create jobs for large groups of people. Usually useful work is performed, and the retarded person may gain some very worthwhile experience which can be used later. Do the national goals of your country include such social concerns?

15. **Priority employment**

Certain jobs are sometimes set aside for designated groups such as war veterans or the handicapped. In Egypt, for example, one found handicapped war veterans monitoring street parking, and in the United States, when a new federal building is opened, for certain jobs, absolute priority is given to candidates from the local rehabilitation agencies. Are there such jobs in your country that can be reserved for mentally retarded persons?

16. **Accommodated business**

In some countries, the blind are permitted to open shops or kiosks in sections of government buildings, and they have the exclusive right to do so. For example, in Senegal, the blind are selling national lottery tickets in special kiosks set up in the public parks. What is going on in your country, or can be modified, to accommodate retarded persons?
17. Cottage or home industries

This is generally piece work or assembly work which can be done in small groups or in homes, work of very high quality but which may probably be of low total economic value. It imposes the problems of quality control and of course, transportation and communication costs may be quite high. But it may be a very desirable social alternative than to permit home-bound retarded persons to stagnate. If you are planning a sheltered workshop which will need to be subsidised anyway, can you afford to leave the home-bound out?

18. Priority production systems

In many countries we are beginning to see some success in governments granting of priority in bidding for products which government uses, or in the supply of services, to groups of handicapped persons. These groups can be organised in a wide variety of ways.

In the US and in Poland, handicapped persons benefit greatly from this procedure, and in Chile I have seen a sheltered workshop of mentally retarded young adults doing silk screening of government linen and calendars. What products purchased by your government can be "set aside" for delivery by the handicapped?

19. Private business

A business can be set up to employ primarily handicapped persons. You can find these in the US, in Mexico, in Ethiopia and certainly many others. Here the rehabilitation leaders, or some businessmen, or through other auspices, a business enterprise is set up to provide employment for mentally retarded persons. It is a business, must be well organised and competitive, must produce a product or services to be marketed. It is a regular business with the important socially redeeming value of providing work for handicapped persons.

The business can be a co-operative, with profits going to the members, or the proceeds can be used to offset the cost of other activities for the mentally retarded, such as the sheltered workshop. A place in Ecuador makes fine house doors for the luxury market, and the proceeds support other sheltered employment.

20. Monopoly business

In some countries where the state manages most of the economy, as in Poland and similar countries, certain economic activities are reserved for the output of handicapped persons, including the mentally retarded. Poland, where the enterprises are also co-operatives, is an excellent example.

One can imagine almost any country represented here securing an exclusive license to produce something now being imported, and therefore having a sort of protected enterprise.

A variation of this type of economic activity is the Redflag Rubber and Hardware Co., in Peking, administered by the
municipality, and serving several categories of handicapped persons. In addition, they have used some of the "accommodations" mentioned previously, using special buses to transport handicapped workers back and forth, and living quarters are provided for 50 disabled workers.

21. **Subsidised enterprise**

The subsidy is by the government, and the best example that comes to mind is REMLOY of Great Britain. REMLOY factories, large and small, have been established to employ handicapped persons who are otherwise not absorbable in the regular labour market, and they do business just like everybody else, with competitive prices, regular wages, marketing campaigns, and so on. The government subsidises the system to an agreed level. Close to 9,000 people are kept off welfare rolls, they work in dignity and can support their families. Such subsidies may be an economic alternative to direct assistance payments, and the system yields products of value to the national economy.

22. **Employer incentive schemes**

Some communities are thinking of providing various incentives to employers to increase the probability of hiring mentally retarded persons. One can think of a national policy which grants tax rebates or cash incentives to employers who hire the handicapped. This gives a handicapped person a chance to try out a job, and to learn about it. Of course, one cannot expect an employer to maintain indefinitely a substandard product, although the incentive, continued over a long range, might permit this. OJT and similar programmes are also clearly incentive schemes.

23. **Activity centres**

These are mentioned here because, sooner or later, all rehabilitation centres, whether they have a sheltered workshop or not, must make a decision about the handicapped worker who produces at a rate of 30 per cent or less. Or sometimes a sheltered workshop may become an activity centre through lack of economic activity, or through improper attention to standard production methods, through poor supervision, indifferent attention to task adaptation, and so on.

In activity centres we do not expect very significant economic activity, and there will need to be rather heavy and permanent subsidisation. These centres belong in the list of activities which must be considered for the socialisation of severely handicapped people, and to provide relief for the family. They are designed to provide stimulating social and educational experiences which at the very least prevent mentally retarded persons from stagnating and deteriorating and thus we can avoid subsequent and longer term increased disability and dependency which will lead to greater problems and more expense.

Many experts believe that the same facility should not house both very low economic producers such as belong in an activity centre and a worklike activity such as a sheltered workshop.
24. **Sheltered workshop**

Following is the definition in the recently revised ILO Glossary:

Is often, but should not necessarily be, a subsidised establishment which provides sheltered work to disabled persons and which has two primary objectives:

1. to offer transitional or short-term employment as work preparation and training for competitive employment; and

2. to offer long-term employment for disabled persons who, because of the severity of their handicap, are unlikely to be able to secure and retain competitive employment.

May provide some or all of the following services: medical and parasomedical assistance, vocational evaluation, job guidance and counselling, work adjustment training, and selective placement.

In countries with extensive underemployment or unemployment, **sheltered employment** may offer opportunities to those disabled persons who might otherwise have not been able to secure competitive work.

It is important that we define that word "shelter" and distinguish it from "accommodation". "Accommodation" is something done so that an employee can perform at a normal standard; thus a job can be restructured, transportation to and from work provided, etc. Under "accommodation" jobs or working conditions are modified to meet the needs of workers, rather than the other way around. "Shelter" refers to things which are done which accept some degree of reduced production, and usually, directly or indirectly, subsidise the missing production. Thus changing the working hours or way of doing a job is "accommodation", while increasing supervisory time is "shelter".

The activities for mentally retarded persons which I have described previously have either "shelter" or "accommodation", or both, as components.

While the ILO definition suggests the possibility of a wide range of activities, actually national economic and cultural practice and the existence of other related and collaborative systems dictate the character of a particular sheltered workshop. In the United States you are likely to find a very wide range of activities, whereas the European practice seems to be to provide mainly extended employment. In Peru and Mexico, two sheltered workshops provide only extended employment; a large one in Costa Rica offers mainly vocational training and placement, several workshops in Colombia provide training, employment, preco-operatives, and another in Santo Domingo does everything. All are equally considered sheltered workshops since subsidies are required. Some workshops which show a profit are also considered sheltered workshops since some of the income is not earned income.
What can a sheltered workshop do?

Of course, any and all of the activities previously discussed can be part of an over-all economic activities programme. You are probably most familiar with subcontracting, contracting for the services of a work crew, selling training services, making things and selling them, repairing things and selling them, and a few other things.

No one should tell you what economic activities to undertake; this is a determination that is clearly based upon community leader advice, on the economic and market conditions prevailing, on staff training and administrative skills, and naturally, on the skill level of the workshop clients.

I do know that you should probably not have your clients making handicrafts to be sold one week a year at a church or hospital bazaar. That is charity work, not rehabilitation. A sheltered workshop should be a business, even if it is almost always a losing business.

For and against sheltered workshops

You have heard and you know that there are many different kinds of economic activities theoretically available to mentally retarded persons, and you know that some kinds are more difficult to achieve than others. We can, however, agree that for some severely retarded persons, the only alternative will be a sheltered workshop.

Let me suggest a number of salient features or possible problems which must be addressed:

(a) Leadership - You cannot do it alone. It seems that the first task is to broaden the range of skills available to your programme. Does your board have representatives from the government, from the community, from the business or commercial sector? Are you using their skills and knowledge? Are you expanding your team so that concern for mentally retarded persons changes to a concern for persons?

(b) Size - Is your operation large enough? It is a serious mistake to start too small. Expensive leadership, supervisory skills, other resources, need to be spread out over many to be economical. A large workshop or programme can do many things, can attract many different resources, and can be more interesting. It can allow more room for a wider range of disability.

(c) Integration - Should you integrate your services with other handicapped groups? Absolutely YES. It is almost criminal to compete with other groups for meagre resources when far richer opportunities can exist with a combination. Are there other programmes, other workshops? If so, then join them.

You will again broaden the basis for support by including other groups, and you will win their advocacy.

(d) Programme - Did you draw up your building plans before you wrote your programmes? What are your clear written objectives? How will these objectives look five years from now? Who is keeping the programme current?
If you are going to manufacture things, does anybody know how to run a factory, or a business? If you are going to sell things, where is your marketing specialist?

Avoid the land-building programme syndrome! Under this very common affliction there exists a very strong desire to own land, something permanent for the handicapped. Usually government or someone eventually donates a parcel of land. Never mind that the land is in the wrong place for a workshop, i.e. poor utilities, poor transportation, away from other people and industries. Land is land!

Once the land is in hand, a building must be built. Architects must be the most generous people on earth, because everyone seems to have building plans.

The programme is usually thought of last, and then it is designed to fit the building which was designed to fit the land. Since this is the clear reverse of any planning principle, you are cautioned to think first. A sound programme may even minimise the need for one's own building on one's own land.

(e) The token - If you know that there are 1,000 mentally retarded persons in your country, and if you are providing excellent services in a sheltered workshop for 50 of them, are you really doing anything significant? Does your sheltered workshop use up most of your leadership talent and other resources, leaving little time to do anything else? Does your community or country believe that because you have a successful workshop that the problem of mental retardation is being solved?

(f) The handicapped - Are you employing handicapped people as staff in good jobs, not only providing work for them within your own organisation, or realistic training, but providing a good example? Are there any handicapped persons on your governing body? What feedback is provided to your training programme by your graduates?

General comments:

Many consultants to new and developing programmes for the mentally handicapped are very prone to caution against the historical errors of warehousing large numbers of persons in monumental institutional systems. They congratulate themselves and preach normalisation and sheltered workshops. However, there is the danger that sheltered workshops in developing countries will lead to stigmatisation and other deleterious effects, in much the same manner as large institutions have ruined the lives of mentally retarded persons in the United States.

Sheltered workshops are indeed immensely popular. They are seductive to our programming, relatively easy to control, concrete and visible. They do provide a very useful activity for severely handicapped people. They offer concrete demonstrations of what can be done, opportunities to train leadership, and to inform the public. No doubt they should be part of every comprehensive programme of assistance to mentally retarded persons.
Almost all sheltered workshops lose money, thus will need permanent subsidies. Almost all sheltered workshops pay back benefits to their communities in excess of the deficits, even in developing countries, and we are beginning to have more and more evidence of this fact.

However, I am suggesting rather strongly that the sheltered workshop which everybody wants to create with its building and staff, may not be the best solution in your country or in your community, and it may, in fact, do a disservice to many, many handicapped people. I think we all ought to consider instead rather complete systems for exploiting the potential of mentally retarded persons and keep the sheltered workshop as only one tool in this entire system.

The very establishment of a sheltered workshop may pre-empt the available leadership, and by its existence, preclude the exercise of advocacy towards neglected alternate economic activities which must be developed. Who will develop the work crews? Who shall secure the concessions from government and industry for broader and more innovative job opportunities?

Instead of sheltered workshops, which are designed for a narrow segment of the disabled population, but which perform serve almost the entire group in developing countries, and which serve the group badly by avoiding normal and logical alternatives, the term and concept should be replaced by employment development centre. Such a centre, after all, will try to develop economic opportunities for rehabilitated people, and that is what vocational rehabilitation is all about.

Employment development centres are advocates for the handicapped. Much less narrowly organised that the traditional sheltered workshop, they take responsibility for creating the job opportunities described under the rubric "workshops without walls", OJT, work crews, they seek quotas or selective treatment of jobs for the handicapped, and involve the business community in a variety of ways. Sheltered workshops will be but one tool to be used, not the whole thing. Leadership is the name of this game.

What I am trying to suggest is that many of us need to raise our eyes and exercise the kind of leadership which will truly prepare our countries and our communities for the economic participation of the mentally retarded. I am not so sure that a successful sheltered workshop is the best way to do this. True, we do need demonstrations and we do need pilots and we do need to have something concrete to show somebody what can be done and I am not saying that we should not do these things but I am saying that we cannot rest with these things and at least part of our energy, part of our resources must be applied at the national level.

The successful rehabilitation programmes in England, in the United States, in Costa Rica, and in other places did not actually come about because somebody started a successful workshop. Every history will show that only when organised groups, be they professionals, in most cases they were parents, when they became organised and when the were able to sensitize their governments and their communities and their professionals in the existing systems to the national needs that existed, it was only then that decent well-funded, high-quality, large programmes were possible. I cannot
over-emphasise the importance of a continuing significant relationship with government ministries and with government political leaders, if in fact you wish to accomplish employment for the mentally retarded.

In the United States, the vast proliferation of facilities for the mentally retarded is a matter of rights and a matter of politics. Our national consciousness has been pricked and sometimes badly damaged by a series of judicial actions which are possible in our culture which may not be possible in yours. By a heightening of national awareness of how we have been treating handicapped people there is little question any more but that mentally retarded persons have a right to their share of national resources.

In Costa Rica, rehabilitation of the handicapped is a matter of manpower necessity. There is hardly any unemployment in Costa Rica and our Goodwill affiliate in San José places practically every one of their graduates. Of course, right now they are dealing with not so severely handicapped persons and there is beginning a pile up of those who are not immediately placeable in some of these good jobs but I think they will have little difficulty in securing governmental adjustments to accommodate their continued support of the more severely handicapped.

In Poland, for another example, it is a matter of social policy that all citizens participate in economic life as equally as possible. Therefore, in a managed economy such as Poland the Government can grant a monopoly on the production of certain essential goods and services; too, they happen to be co-operatives which produce these same goods and services. For example, I believe that all office supplies, among many other things, in Poland are produced only by the handicapped and nobody else can do it. Concomitantly with this, whatever it takes to bring a handicapped person to economic productivity such as training, evaluation, counselling, etc., is freely engaged in by agencies of that government.

We have all heard questions about the wisdom of giving subsidies or making investments for handicapped persons in developing countries where unemployment may be high for the able. Sometimes our response has been a little defensive and has caused our work to take on a charitable character instead of being truly developmental.

The critics have said that we can only give a low priority to your rehabilitation programmes, we have to wait until the country is more developed and we can afford it. This is a very dangerous philosophy and we should take care to combat it every time it appears. The implication is that only the able bodied and intelligent have value (and you had better believe that all of us here are only temporarily able bodied) in our country. But, if we really wait until all able people have jobs and then permit the handicapped to be citizens, what kind of a society will we have created?

By our inattention we will have continued to destroy a whole population of fellow citizens, we will have polarised attitudes, and erected a vast experiential barrier impossible to overcome.

We must insist upon the citizenship and value of every one of us, handicapped or otherwise. We must insist, whatever the form of
society, that mentally retarded people are a part of that society. They have a right to full participation and they cannot wait. We must avoid programmes which may continue to segregate and to stigmatise the mentally retarded person and to deny him the citizenship of the country of his birth. This is one of the more subtle mistakes that has been made in the developed countries. Nations relatively new to rehabilitation programmes must avoid not only the costly monuments of the past, but also that unconscious spirit that limits and institutionalises just as surely as bricks and mortar.
Bibliography


1. Antigua's programme in the field of rehabilitation of the mentally retarded

by

Mr. C.J. Roberts

The problem of mental retardation in Antigua, as serious as it has been, remained until quite recently a family or household problem and those who have been unfortunate to have this handicapping condition were divorced as it were from society and considered non-eligible to share in normal human and social activities. Services of any kind for the moderately and the severely mentally handicapped were virtually non-existent whether as government or private undertaking until about the middle of 1973 when a small group of voluntary social workers among whom was a doctor and a parent of a mentally retarded child got together and formed the Antigua Association for the Mentally Retarded with the simple purpose of providing some kind of service for mentally retarded children.

Following a series of training sessions for volunteers - mostly housewives - a screening programme started and before the end of the year four classrooms were prepared and equipped for various activities in premises of the Church of Christ where some 25 children (2-13 years of age) from various parts of the island started sessions on 12 November 1973. The first programme co-ordinator was one Mrs. Peter Vreeswijk assisted by some 23 volunteers who devoted one or two regular mornings a week each. However, the formal opening of the school took place on 10 January 1974 when the programme was given the full blessing of the Ministry of Education and Culture. It is to be noted that during the first year of operation all services were voluntary and the general response was very encouraging indeed.

During the second year, Miss Eleanor Schonfeld, a trained teacher and missionary attached to the Church of Christ, succeeded Mrs. Vreeswijk as co-ordinator, giving full-time service for a monthly stipend of ECS100, the school's annual operating cost being in the vicinity of ECS3,500 at that time.

This income was derived mainly from fund-raising activities sponsored by the Association as well as from members' subscriptions, and contributions from individuals, business firms, service clubs and other organisations. The Association also owes a great deal both to the National Institute on Mental Retardation of Toronto and the Special Projects Branch in the Ministry of Education, Ontario, who donated large quantities of toys, educational and training material to the School and Information Centre.

In 1975, the Association sought and obtained the services of a trained Peace Corps Volunteer (thanks to the Ministry of Education) as well as another full-time teacher who was paid ECS200 per month by the organisation. The year 1975 also saw the first annual government grant of ECS1,500 which greatly eased the financial burden on the Association and made it possible for us to start our first training programme overseas.
One teacher attended a workshop in St. Lucia while two young Antiguan volunteers - Miss Hyacinth Brown and Mr. Franklin Jones - were sent on a nine-month training course at the St. Coletta School, a Roman Catholic residential facility for the mentally retarded, in Jefferson, Wisconsin. On their return in 1976, the Association successfully negotiated with the Ministry of Education to employ these two youngsters in the regular system and send them on secondment to the School for the Mentally Retarded.

Following the Caribbean Workshop on "Planning Special Education Services" held in Jamaica, 5-12 December 1976, Antigua sought to implement a recommendation which had to do with the setting up of a National Committee for Handicapped Citizens, with advisory, co-ordinating and planning responsibilities. As a result the Antigua Council for the Handicapped, comprised of representatives from both government and private agencies, came into being on 25 April 1977. One of the Council's main objectives as being to assist government and other interested organisations in Antigua in identifying the size, nature and scope of the problem of handicap among persons in the State.

At this point in time, the extent of the problem of mental retardation in Antigua is not really known since it has not yet been possible to carry out any scientific investigations or surveys of any kind. However, the report of a survey carried out in Barbados recently by Mr. Norman Phillips, ILO Regional Adviser in the Vocational Rehabilitation of the Disabled, is receiving active consideration by the Antigua Council for the Handicapped and the Ministry of Labour with a view to carrying out a survey in due course.

As mentioned earlier, apart from the School for the Mentally Retarded which is operated by a voluntary organisation, there are not in existence at this time any vocational rehabilitation and training schemes for the mentally retarded, but the Association has been holding talks with the Ministry of Education and Culture who are looking into the possibility of taking on a bigger responsibility re. staffing and accommodation.

The possibility of a sheltered workshop is being envisaged but not in the immediate future, unless a fairy godfather or a godmother comes along. In the Antiguan context, however, this type of workshop would have to cater to all classes of handicapped persons including the physically disabled.

Some 12 youngsters over the age of 16 from the School for the Mentally Retarded have been asked to stay at home pending the setting up of a workshop, while a goodly number between the ages of 8 and 16 have dropped out from the school because of difficulties which some parents experience in getting the children out to school. Some of these problems could be overcome if we had the quality of staff to cope with the situation. With the mobilisation of our resources, however, we look forward to seeing some improvement in the near future.

Standing high on the list of priorities for Antigua are the following:

(a) better accommodation for the School for the Mentally Retarded;
(b) a workshop to cater for handicapped persons over the age of 16;

(c) the training of personnel in the field of mental retardation as well as vocational rehabilitation, and these should include physiotherapists, speech therapists, occupational therapists, etc.;

(d) a survey to determine the nature and extent of handicapping conditions in the territory.

This Seminar, I believe, will assist in finding solutions to some of Antigua's problems as well as those of the other participating countries.
Because the percentage of mental retardation in the Bahamas is minimal, its seriousness and the attendant effects cannot be dismissed or overlooked. Although to date reliable statistics have not been compiled in the Bahamas, like in other countries, the mentally retarded are presumably accountable for about 3 per cent of the nation's population.

Interest in the mentally retarded has only recently been accelerated, therefore, training schemes are still in their embryonic stages. There are three schools which cater to the training of these individuals. The Stapledon School for Mentally Retarded and the Grand Bahama School for Exceptional Children are both under the direction of the Bahamas Association for the Mentally Retarded with the Government taking the responsibility of supplying teachers and providing a grant. The third school, Hopedale School for Exceptional Children, is a privately run organisation.

The Stapledon School caters to the training of both educable and trainable mentally retarded. The school, although it lays the foundation for vocational training, cannot promise job placement for all its students as opportunities are not available at the present time. This area, however, remains a major concern of the staff of Stapledon School.

The school's programme is geared towards the preparation of students for specific jobs that may be more readily available to them. Learning experiences concomitant with such jobs as food store packing and storing, gas station attending and mechanic and carpenter's helpers are provided by the school environment. Subsequently, when opportunities become available, students are allowed to go out for half a day until it is felt that they have adjusted to the new environment.

Some students from the school have been placed at Abilities Unlimited. This is a multi-diagnostic sheltered workshop catering to all forms of handicaps and is a product of the Bahamas Council for the Handicapped.

Household goods such as brooms, coat-hangers and pot scrubbers are made. Furniture is manufactured from PVC pipes and souvenirs in ceramics. Not only do they manufacture but they repair and refinish wood, iron and aluminium furniture, upholster chairs, car and boat seats, repair invalid furniture and appliances. Book binding and processing of stamps are also carried on among many others.

The supervisory staff of Abilities Unlimited is a group of individuals, each having experience in his particular area of supervision. Presently, I am not aware of any training programmes for supervisors of Abilities Unlimited.

Training of staff for the school is achieved through government scholarships. Other large organisations provide awards
for the training of teachers also. Two such organisations which have already made contributions towards this are City Markets and the Rotary Club of East Nassau. Recipients of these awards must go abroad for training as there is no institution for this purpose in the Bahamas.

Besides the teaching staff and the grant, the Government also provides health and social services. Doctors and dentists are available at the hospital. Child Guidance assesses and recommends students for the school. The social worker goes into the homes and the speech therapist looks after problems pertaining to speech.

Without the support of the community, the progress of the school may be retarded. The school's Parent Teachers Association and other organisations have contributed much-needed funds and equipment. American Friends of the Bahamas donated, on several occasions, a bus to be used in transporting students. Service clubs have donated various supplies and equipment. Scholarships have been awarded and donations of money. Donations of time, money, equipment, etc., have been numerous.

We are grateful to our many friends who have contributed money or otherwise over the years and look forward to their continued support. The need for more and better facilities to cope with the present roll and the growing waiting list has been evident for some time. Fund raising committees have raised a sizeable sum for the construction of a new and adequately supplied building on a plot of land provided by the Government. Day-to-day expenditures of the school have decreased that sum, along with other problems.

Work has already begun on one phase of the building project and although it will not contain the amount of space hoped for, it will greatly alleviate the cramped and unsatisfactory conditions that are presently endured. Included in this phase is provision for a sheltered workshop where those students who are unable to adjust or integrate will be able to work under supervision.
The vocational rehabilitation of the handicapped is not a new concept in Barbados since there exists a workshop for the mentally ill at the Psychiatric Hospital, a workshop for the blind and a small workshop which is attached to the Challenor School for the Mentally Retarded.

In 1976, the ILO did a study and made recommendations for the vocational rehabilitation of the handicapped. A survey of all handicapped persons was done but the result obtained was not a reliable indication of the extent of handicapped persons in the country. It is, however, estimated that 3 per cent of the population of 247,300 is retarded when the mildly retarded and the learning disabled are excluded.

During the survey, mental retardation accounted for 46 per cent of the male registrations and 47 per cent of the female registrations – only 391 mentally retarded persons were registered.

The report gave guidelines for the establishment of a special placement service to deal with the placement of the handicapped. Subsequently, an officer worked part-time with the placement of the handicapped; her work included placement of retarded persons from the school.

The Ministry of Labour has a Labour Department which deals with the recruitment of people for local and overseas employment. The Youth Employment Section of the Ministry deals with the placement and vocational guidance service for persons under age 20.

Last month, the Special Placement Officer was assigned to work full time with the registration, placement and vocational guidance of the handicapped.

The Special Placement Officer reports that of 15 retardates who were recently interviewed for possible placement, 5 are now permanently employed, 3 found work on their own, 1 is due to enter the polytechnic and 2 were not fit for open employment.

It was observed that those who were interviewed were mildly retarded; there seems to be little hope for the placement of the moderately and the severely retarded in open employment because of their limited mental capacity and pre-vocational training.

Any plan for the vocational rehabilitation of the mentally retarded is dependent on the quality of the special education services which are provided.

The Challenor School offers full-time training for the retarded, this school was started in 1964 by the Barbados
Association for the Mentally Retarded and the Rotary Club. The Government gives an annual subvention of over $30,000. At present there are 71 children on roll and approximately 185 on a waiting list (applicants over 21 were not included on the list). There is a workshop attached to the school (the building was donated by the Lions’ Club); it offers training to those pupils who have reached age 16 and have done some classroom training in basic self-help and academic skills. The pupils are taught carpentry, tile work, leathercraft, coppercraft, rug making, embroidery and sewing. Some of the products are marketed at the Gift Shop which is managed by the Association and some are sold in a large department store in Bridgetown. The profits made from the sale of these items are not always shared by the pupils but are often returned to the Association to supplement the cost incurred in supporting the school and the workshop.

In 1974, a Swedish consultant was asked to study the handicapped in the country and advise the Government on the setting up of educational facilities for each group. The report assumed that educational facilities will have to be provided for at least 495 mentally retarded persons over the next nine-year period. The report recommended the integration of a class of mentally retarded children in a normal primary school.

The Barbados Educational Act, 1975, states that the Minister may, for the purpose of ascertaining which children require special education treatment, cause such investigations to be carried out as he thinks fit. After considering the results of such investigations he may take such steps as he thinks fit to provide for education of such children requiring special education treatment.

There is legislation to make provision for the education of the handicapped - there is a school for the blind and the deaf but there is no government school solely for the mentally retarded.

In 1976, the Ministry of education made provision for the education of 12 mentally retarded children in a special class in a normal school; there are now 26 children on the roll and 45 on the waiting list of this pilot project class. The children are taught self-help skills in two specially equipped classrooms but they join the children of the normal school for social activities.

In September, a class of 15 children will be assigned to a school on the compound of Erdiston Teacher Training College; with the assistance of the project HOPE, the class will provide practical training for teachers who opt to do special education as part of their course. Hopefully, this arrangement will provide the system with trained teachers who will be capable of working with the mentally retarded when more classes are added to the normal schools.

There are still large numbers of mentally retarded persons who are not attending school or workshop because:

(a) there are limited educational facilities for all degrees of the mentally retarded;

(b) there are no sheltered workshops which will provide the trainable retardate with the opportunity to earn a living.

Financial support of the agencies for the handicapped is mainly provided by the following voluntary organisations, who also assist with the planning of seminars and conferences:
The Chesire Foundation supports the Thelma Vaughn Residential Home for the Handicapped; there are plans to build a new home to provide day-care facilities and a workshop for the older residents.

The Barbados Association for the Mentally Retarded provided education and limited pre-vocational rehabilitation services.

The Barbados Association of Parents of the Handicapped is presently making plans for an early stimulation project for the handicapped. The Association also assists with the planning of seminars for parents.

The Association of Occupational Therapists offers advice to the other voluntary groups; one of its members is the tutor in charge of the Occupational Therapy Assistants' Course which is conducted at the Barbados Community College.

All of the above-mentioned associations are members of the Barbados Council for the Handicapped which was formed to pool the resources of personnel and money and establish links with overseas organisations on behalf of all the affiliate members.

The Council is an affiliate member of Rehabilitation International; it is also a member of the Partners of the Americas Programme and works with CINR to plan programmes for the retarded.

In November 1977, two representatives from Partners of the Americas conducted a seminar in Barbados to provide training in sheltered workshop supervision in preparation for the establishment of sheltered workshops. The Partners' tutors recommended a work study and pre-vocational training for the Challenor School.

The Barbados Council for the Handicapped saw the need for creating more public awareness of the abilities of handicapped persons. With the help of an American agency, the Council arranged for the broadcast of slogans on radio and television. As a result of this, several inquiries have been made about the services for the mentally retarded. Indications are that there are many adult retarded persons whose families are concerned about their inability to earn some money to supplement the family income.

The Ministry of Labour and Community Services, through its Welfare Department, gives a weekly allowance to the blind, the physically and the mentally retarded who are not employable because of their disability.

The Ministry of Health and National Insurance offers the same health care and benefit services as it does for able-bodied persons, with the improved health care there will be an increase in the life span of the mentally retarded, therefore gainful employment opportunities will have to be found for a larger number of adult retardates.

Employers in general do not discriminate between a handicapped person and a normal person as long as the handicapped person is capable of doing the job; the question is now asked whether the employers will undertake to train a retardate for his job and whether the retardate has the mental capacity to benefit from on-the-job training.
Vocational training is provided at the Hotel School, the Polytechnic, the House Craft Centre, the Government Handicraft Centre and Adult Education Centres in government schools. Each of these training centres require at least a primary level of academic achievement and entry is on a competitive basis because there are more applicants than vacancies. Many of the supervisors of these centres report that mentally retarded persons hardly ever apply for entry.

Since the provision of services for the handicapped is an expensive undertaking, there needs to be closer co-operation between government and the voluntary organisations in the establishment of workshops to offer pre-vocational training to retarded persons. The positive attributes of the retardates could be showcased for the information and education of the public and the employers.

References

The Barbados Education Act, 1975.
4. Rehabilitation of the mentally retarded in Belize

by

Mrs. L.A. Lopez

The education of the mentally retarded is comparatively new in Belize and as such there is a problem in giving a reliable report as to the extent of the problem.

The reasons for this are:

1. No reliable survey has been done. Belize is divided into six districts - Belize City being the largest and having the most known cases. The remaining five districts are yet to be surveyed.

2. Education of the mentally retarded is not compulsory. Parents with retarded children who wish their child to attend this institution would seek advice from the Education Department or teachers connected with the institution.

3. There is no screening in normal schools making early detection almost impossible. Most children are referred from the normal school.

4. Available facilities have only been able to cater for the needs of approximately 70 children between the ages of 6 to 17 years - during the period 1967-1978.

To date there are no district vocational rehabilitation and training centres. One school (Lynne School in Belize City) exists to service the whole country and can only accommodate a maximum of 30 children. Classes are held three times weekly for children over 17 years, supervised by a member of the staff with the assistance of voluntary help from service organisations, notably the hospital auxiliary. It is hoped that with the expansion of the existing facilities children will not necessarily leave when they have attained the age of 17, but when they have acquired such skills that make them independent to go out into the world of work in cases where their abilities permit.

Employment conditions are inadequate with regard to the mentally retarded and there is no legislation to protect the rights of the handicapped. So far there are only two cases that have been reported; one boy works in a church parish as a handyman and the other is apprenticed in a furniture shop. Others are at home with their parents helping with the chores around the house.

Social sector:

1. There is an association for the handicapped which aims to provide parents' support, parent-to-parent schemes, counselling and training;

2. Plans are being made to extend and improve existing services by means of facilitating and developing more training opportunities and wider utilisation of voluntary personnel;
(3) the association plans to stimulate the development of new programmes to help handicapped persons develop and integrate, e.g. early stimulation programmes, vocational rehabilitation, and recreational activities;

(4) to examine existing legislation to see where changes may be necessary to ensure the rights of the handicapped persons to protection from exploitation and to participate in community activities and programmes;

(5) to develop public education, to improve public attitudes towards handicapped persons.

Financial support received from service organisations has been very generous:

(1) the Lions International, which includes the Lioness Club and the Lions' Club, provides for the upkeep of the property which includes the painting and repairing of buildings, a feeding programme and donation of equipment;

(2) the Hospital Auxiliary gives financial support, supply of equipment, helps with social activities, gives voluntary assistance, especially working among the older children;

(3) the Church groups help with the planning of social activities and give financial support;

(4) the Parent Teachers' Association organises fund raising to supplement existing resources.

The staff of the Lynne School is locally trained with qualifications similar to normal school teachers; specific training is provided in the form of local seminars with experts from the Caribbean Institute on Mental Retardation and personnel from Michigan State University Department of Special Education, visiting lecturers in the field of special education, overseas training for members of staff through the Commonwealth Teachers' Training Programme or Technical Co-operation Training Programme.

There is need for total acceptance of the retarded by the public. There should also be legislation to protect the rights (especially employment) of the mentally retarded. The setting up of sheltered workshops is a great necessity.

It is hoped that within the next few years a sheltered workshop will be set up for the handicapped. This should be linked to the Lynne School and the Stella Maris School (for the physically handicapped).

Special education units in the regular classroom should be increased in number. Already there are two of these in the area of mental retardation.
5. **Programmes for the mentally retarded in Bermuda**

by

Mr. N. Caines

Bermuda has made significant advances in the fields of education, health and social services over the past decade. Among the many improvements which have been made, those which relate to services and programmes for the handicapped would seem to have improved the greatest.

At present, a mentally pre-school child has access to a number of government and private day-care and nursery programmes - provided that the child is not severely physically handicapped. If the child is severely physically handicapped as well as mentally retarded, placement on a day-care or in-patient basis can be arranged on the programme for such handicapped children at St. Brendan's Hospital. Mentally retarded children who are not severely physically handicapped can find placement at the Day Training Centre after the age of three.

In either case, St. Brendan's Hospital and the Day Training Centre placement requires complete parental support and cooperation. The services and programmes are free, but no child is placed in these programmes without parental approval. Children with a moderate degree of mental retardation may find it possible to attend the government or private nursery schools and move on to the regular primary schools at five years of age.

Frequently, however, these children quickly become frustrated with the regular infant level programme because the regular school programme is too difficult for them and, furthermore, the size of the classes make it almost impossible for such children to receive the kind of individual instruction that they need in order to progress at school. As these children are identified by the teachers and principals, they are then referred to the special services staff at the Department of Education for individual testing. When the test results indicate that the child will require a special education programme, the parents are consulted and their approval is obtained prior to placement in a special education programme.

Since there are no special education programmes in the regular schools for these children, placement would likely be made in one of three special schools - Cedar Grove School in Southampton, Devon Lane School in Debonshire, or Woodlands School in Pembroke. Placement in these special schools would also include consideration of where the child lived and the age of the child concerned, since Devon Lane School will not take children over the age of 13.

At the age of 16, some mentally retarded young people still require an educational setting. Not only do the mentally retarded develop slowly in the early years, but they usually take longer to develop socially and emotionally into adults.

The Opportunity Workshop in Prospect has been specifically designed to include some mentally retarded people. The Workshop
also contains non-retarded young people and adults who usually have some other form of handicap such as deafness or physically handicapped. The training programme at the Opportunity Workshop is designed to teach the basic work-related social and technical skills so that the mentally retarded trainee can be eventually employed in the community and live a functional independent life. There are some trainees at the Workshop who will require a different sort of involvement. These trainees are sufficiently handicapped and subsequently their chances of coping in the community on a competitive basis are minimal. They will either remain on a sheltered work basis, or they will eventually require placement in the Occupational Therapy Unit at St. Brendan's Hospital.

St. Brendan's Hospital continues to offer day programmes to those who are severely or profoundly mentally retarded yet can still live at home. The Hospital also offers residential care for mentally retarded people (children and adults) who are unable to be cared for at home. Mentally retarded residents at St. Brendan's Hospital, who do not attend the Day Training Centre, the Opportunity Workshop or work in the community, can find involvement in training from the services and programmes which are part of the hospital.

All those who work with mentally retarded Bermudans are proud of their chosen field and most enthusiastic of what they do.

Special services:

(1) educational Centre at St. Brendan's Hospital;
(2) special classes at St. George's (education);
(3) Oleander Ward - St. Brendan's Hospital (moderately subnormal);
(4) residential long-stay wards (3) at St. Brendan's;
(5) children's ward at King Edward Memorial Hospital for assessment, physical, medicine, medical specialist, physiological testing by Department of Education.

Community support:

(a) committee of 25 support the work greatly;
(b) Bermuda Alliance linked with the Philadelphia Association requires the services of attendants 24 hours daily, during sleeping and working hours - an enthusiastic programme;
(c) St. Brendan's Volunteers Association - 60 members;
(d) summer camp programme volunteers.

Training of special staff

All staff members within the last five years are specialised trained in the United Kingdom, Canada and the United States.
Problems related to reintegration of mentally retarded:

(a) lack of social clubs;

(b) lack of handicapped games;

(c) families with retarded members need to be relieved periodically of their full responsibility.

Opportunity Workshop Programme

In 1965 a group of people in Bermuda banded together with the idea of helping the mentally handicapped children in the island. There were at least six wealthy parents of mentally retarded children on the committee. This group was soon to be known as the Committee of 25, which still plays a major part in the community dealing with the mentally retarded children. At that point, the Community of 25 brought a man in from England and the first sheltered workshop in Bermuda was established.

In 1969, the sheltered workshop was offered to the Government and was taken over by the Ministry of Health. In 1972, the Minister for Health was moved and became the Minister for Education. At this point, the sheltered workshop was making its presence felt in the community so much so that the Minister of Education decided to bring the Day Training Centre and the sheltered workshop over with her into Education. This move presented a few problems which caused the then supervisor to leave her post and return to St. Brendan's Hospital as an Industrial Therapist (she was an O/T before coming to the sheltered workshop). The fact that we were under Education made us feel entitled to all educational privileges but this meant qualifying one's self. This was done within three periods, so we all have qualified teachers at the workshop.

In 1975, the sheltered workshop was moved from its army barracks building with 16 trainees to the old military hospital and given the name of the Opportunity Workshop, in September 1978 we will have our quota of 40. We are limited because of space. The staff at the Opportunity Workshop take pride in being members of this particular staff. The fact that we have such an interested ancillary staff makes our programme very successful.

All staff members report to work at 8.30, since we are a training facility and not a production workshop. Then we hold an assembly at 9.00 a.m. every Monday, at which time we relate the programme for the week.

Programmed in our weekly activity is the ancillary staff. On Mondays we have a social worker with us, on Tuesday morning we have the speech and communications officer. Every other Wednesday we have the psychologist who works with us on case studies and on Thursday mornings we have the health service's doctor who deals with all medical situations.

Since being appointed supervisor in 1977, having acted in that capacity since August 1966, I have implemented an education programme which is seemingly the shot in the arm the Programme needed. The success of this Programme lies in the fact that we have four government mini-buses at our disposal which allows us to programme our activity in the community,
With regard to wages, the trainees are provided with an incentive beginning at US$2.00 basic and according to their progress so is their wage increased - according to the contracts so are they paid. A trainee can or has earned up to US$75 during the course of the workweek. Most of the trainees have bank accounts with some figures going as high as US$600 of which they are permitted to withdraw any amount at any time.

This year, 1978, we took 24 trainees to one of the islands for a nine-day camping programme. What did we hope to accomplish by this venture? The idea behind this scheme was to attempt to see the other side of the trainee that we do not see at night and week-ends. We programmed the activity in a way that allowed us to see as much of the natural ability to care for themselves. We found many of the trainees much more competent than was realised.

The programme was very successful as well as quite an eye opener to the staff. We are in the process of planning Camp Hassina 1979.

According to my calculation, there are 168 hours in a week; the average person works 40 hours and sleeps for about 56 hours, what then are we doing for the mentally retarded with that spare 72 hours?
### Special Schools:

<table>
<thead>
<tr>
<th>Friendship Vale</th>
<th>Cedar Grove</th>
<th>Devon Lane</th>
<th>Woodlands</th>
<th>Day training</th>
<th>Opportunity Workshop</th>
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<tr>
<td>(5 classes)</td>
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<td>enrolment 38</td>
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<td>Age range 5-16</td>
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<td>4-16</td>
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3. Services:
(a) Physical handicaps
(b) Health problems
(c) Hearing deficiency
(d) Visual deficiency
(e) Deafness

Above three schools are designed to deal with mildly and moderately mentally handicapped children. They also serve children who have moderate emotional and/or social problems as well as children with specific learning disabilities.

For those who are severely mentally handicapped who can benefit from a highly structured specially educational programme.

For trainees who have had some form of special education but still require a sheltered environment in order to develop independent skills.

4. Admission procedure
- Referral to the Department of Education, special services, and an individual assessment, followed by a recommendation from school staff and department personnel with parental approval.
- Referral to education or health authorities with parental approval.
- Referral from the community as well as government agencies.

Note: All students recommended for placement must meet with the approval of the respective admissions committees. This is done in order to ensure that the most appropriate placement is made for each student.

5. Aim
- To provide a highly structured and specially educational setting which will allow each child to compensate for and better deal with a handicap.
- To provide a learning environment that will permit each child to develop to his potential by employing specific individualised and small group instructional programmes.
  1. Return to a regular school programme.
  2. Transfer to the older special education programme at Devon Lane School.
  3. Employment.

6. Prospects
- Transfer to a regular school.
- Proceed to another special programme.
- Transfer to one of the special units.
- Opportunity Workshop.
- Employment.
- Protracted shelter.
6. Mental retardation in Colombia

by

Miss M. Zalzman

Basic information on Colombia

Location: Colombia is one of the north-west countries of South America. It limits with Panama, Ecuador, Peru, Brazil and Venezuela and has coasts on the Caribbean and Pacific Ocean.

Area: Its area is 1,138,340 km².

Population: Colombia has approximately 25 million inhabitants, 62 per cent of which is urban and 38 per cent rural. Sixteen per cent are children under 5 years of age.

Capital: The capital of Colombia is Bogotá, and it has about 5 million inhabitants.

Educational system

According to the law, elementary education in Colombia is compulsory and free. However, statistics show that a high percentage of the population remains illiterate. Education is based on 5 years of elementary school, 6 years of high school and 4 years of university or technical training.

(a) Extent of the problem of mental retardation

There are no official statistics showing the exact figure of mentally retarded population.

The "Division de Educación Especial del Ministerio de Educación" ("Ministerio de Educación" being the highest authority on education for mentally retarded) is engaged in the compilation of the data for a future national census of the retarded.

It is estimated that in Colombia, due to problems caused by general deprivation, about 5 per cent of the population is mentally retarded. In a research study done in 1972 by Dr. Francisco Cobos (1972) and a team of collaborators from Colombia and the United States, on malnutrition and mental retardation, it was stated that around 2 million Colombian children of less than 5 years of age are mentally retarded; by 1978, probably this number has increased.

(b) Existing vocational rehabilitation and training schemes for the retarded

The creation of the first specialised institutions for rehabilitation of mentally retarded children arose from the parents' urge to find an adequate location for their children.

Most of these institutions are private and only a few of them have official support. Fees have to be paid and enrolment is limited and insufficient for the population's needs.
To ensure adequate rehabilitation of the mentally retarded child it is necessary to start with early stimulation and arrive at vocational rehabilitation after pre-school and pre-vocational rehabilitation training. To date there is no unified curriculum that can be used as a guide for pre-school, school, pre-vocational and vocational stages for mentally retarded.

In this way each institution elaborates a different programme in relation with its objectives.

(i) **Pre-school period**

In the pre-school period the mentally retarded child must acquire the basic skills (such as pre-reading, pre-writing) that will permit an adequate development of psychomotor co-ordination. In this same stage socialisation and the act of living together must begin.

(ii) **School period**

In this period academic knowledge is reinforced and enlarged (reading, writing, language and mathematics). Simple and intricate handicraft programmes are initiated as a basis for the pre-vocational stage.

(iii) **Pre-vocational period**

The mentally retarded child who starts this stage must learn the use of tools as well as the basic activities that later on will be used as basis in the vocational stage.

In some institutions, during this period, trainees undertake various activities. In others, they are oriented directly towards a specific activity.

Pre-vocational activities developed at this stage are: carpentry, pottery, gardening, sewing, hand basketmaking and cooking.

(iv) **Vocational period**

During this period the trainee must become more adept in the use of tools as well as in the performance and speed required in the different crafts. Vocational training is provided at two institutions. One in Cali, at Tobias Emanuel, and the second in Bogotá, at the Instituto de Rehabilitacion Profesional y Educacion Especial (Institute of Vocational Rehabilitation and Special Education, IRPE).

The vocational training areas at Tobias Emanuel are: industrial sawing, gardening, carpentry and assembly work.

At IRPE, where the vocational areas are binding, weaving and bakery, the evaluation of prospective trainees is made by an interdisciplinary team formed by a psychologist, an occupational therapist, a speech therapist and a designer of instructional material.
In order to accomplish the vocational training, the student must fulfil some instructional objectives. Vocational education is personalised for each student.

(c) **Open and sheltered employment opportunities**

There are very few employment opportunities in Colombia for the mentally retarded. Almost all of them are limited to jobs in assembly work in sheltered workshops under permanent supervision.

In relation to open employment, the creation of vocational training centres now offers opportunity for the mentally retarded to work in the areas in which they have been trained.

(d) **Special supportive services for the retarded in the health, education and social sectors**

The Division of Special Education was created by Decree No. 3157 (1968) of the National Ministry of Education. In 1973, the initiation, functioning and approval of classes with special assistance for the mentally retarded at regular institutions was regulated.

The Division of Special Education promotes and co-ordinates the national policy of mental retardation. The Ministry itself has no special schools for the retarded. Part of the staff's salary of the private institutions for mental retardation is paid by the Government through the Division of Special Education.

Up to 1975 only 1 per cent of mentally retarded children received special education while almost 300,000 were excluded.

(i) **Health sector**

The services offered by the Ministry of Health in the field of mental retardation concentrate on preventive care of mother and child. With this in view, training programmes for nurses and midwives were started. The Rehabilitation Division of the Ministry of Health has started to compile data for a proposed National Board of Rehabilitation Resources. This Board will help to publicise the work of all bodies concerned with rehabilitation and avoid duplication of services.

(ii) **National Social Security Scheme**

Social security assists mentally retarded children until the age of 7. Normal children are assisted only for one year.
(iii) **Social services**

The Colombian Institute of Social Welfare (Instituto Colombiano de Bien-estar Social) was created by Decree No. 17 of 30 December 1968 for the orphan child and family's protection. The Institution co-ordinates with specialised institutions the programmes of mental retardation.

Study courses for parents are organised by the Division of Social Promotion to advise them on the behaviour they must adopt towards their mentally retarded children.

Contacts have been established with different universities of Bogotá with a view to training students of psychology, medicine and social work in the area of mental retardation.

Nowadays, the Division of Social Promotion is studying the number of applications of mentally retarded children of pre-school age for the purpose of creating centres of total care for these children.

(e) **Community support for the mentally retarded**

(non-governmental organisations, parent groups, etc.)

(1) **Institutions**

There are 43 institutions in the whole country offering special rehabilitation programmes but without a scientific discrimination on the levels of mental retardation. Four workshops offer mixed services of vocational rehabilitation as well as sheltered employment, three of which are located in Bogotá and one in Cali.

(ii) **Non-governmental organisations**

- **CONAR** (Comité Nacional pro Retardo Mental). The National Committee for Mental Retardation was created in 1968. As part of the Committee, there are several professionals working in the field of mental retardation. The Committee gives advice to private and national institutions that deal with problems of the mentally retarded.

- **FIDES** (Fundación para la Investigación y Desarrollo de la Educación Especial). The Foundation for the Investigation and Development of Special Education is specially interested in introducing physical activity and sport competitions within the rehabilitation programmes of the retarded.

- **ACEDEM** (Asociación Colombiana para el Estudio Científico de la Deficiencia Mental). To the Colombian Association for the Scientific Study of Mental Deficiency belong professionals concerned with the rehabilitation of the mentally retarded. It is divided into several subcommittees that are in charge of the study and investigation of the problems involving the mentally retarded.
(iii) **Parent groups**

There are four parent groups. They organise fund-raising for the mentally retarded institutions.

(f) **Training of specialised staff**

Occupational and speech therapists, as well as specialised teachers in charge of the rehabilitation of the mentally retarded are trained in the country's universities.

The professionals are trained in the field of mental retardation through supervised training at the institutions for the mentally retarded and at hospital rehabilitation services. Other professionals such as psychologists and social workers have no specific training in the area of mental retardation.

Vocational rehabilitation of handicapped people was started a few years ago but only for the physically handicapped. Training of staff in vocational rehabilitation of the mentally retarded is just beginning.

One of the aims of IBPE in the near future is the organisation of training courses in vocational rehabilitation. Conferences will be held by Colombian trained professionals as well as by foreign guest speakers.

(g) **Unsolved problems related to the social and vocational reintegration of the retarded:**

- The lack of a national policy as well as protective laws related to mental retardation limit possibilities for vocational and social integration. The Government must be urged to approve laws for the protection and well-being of the retarded and their integration in the society from which they are currently excluded.

- Due to the limited budgetary resources of each institution the vocational rehabilitation programmes for the retarded are very limited. The institutions must be provided with vocational workshops and their budget increased in order to ensure that the retarded have the opportunity to benefit from vocational rehabilitation.

- The existing prejudices of most of the population towards mentally handicapped people means that there is a tendency towards segregated rather than integrated services. National campaigns must be organised all over the country to sensitise the community and change their attitudes towards the mentally retarded.

(h) **Plans for the future**

Plans for the immediate future are:
- to urge the Government, through the existing co-ordination organisms, to promote more effective measures in the areas of health, education and jobs for the mentally retarded;

- to initiate rehabilitation programmes as soon as possible through the implementation of early diagnosis and adequate treatment;

- to include in the national policy of care for the mentally retarded, the underdeveloped and rural regions;

- to intensify the training of specialised staff and provide increased help to underdeveloped and rural regions;

- to help and orientate the parents of retarded children;

- to co-ordinate the curricula of the institutions of special education in order to make learning easier and prepare the students for entry to vocational training;

- to create centres of vocational rehabilitation taking into consideration the limited job opportunities for the mentally retarded;

- to involve the private and state enterprises in the creation of co-operative societies that will offer work opportunities to those mentally retarded who have been vocationally trained;

- to awaken the interest of private and state enterprises as well as parent groups in establishing sheltered workshops for the mentally retarded who are unsuitable for open employment;

- to train the mentally retarded using SENA's (National Training Service) workshops and instructors previously trained in this area.

Reference

Francisco Cobos, "Lipids, malnutrition and the developing brain", Ciba Symposium, 1972.
7. Vocational rehabilitation of mentally retarded people in Costa Rica

by

Dr. C. Mora

and

Mr. J.A. Astacio

A. Definitions

For this paper we accept the following concepts:

- **Rehabilitation**: As applied to disability, this is the combined and co-ordinated use of medical, social, educational and vocational measures for training or retraining the individual to the highest possible level of functional ability.¹

- **Vocational rehabilitation**: That part of the continuous and co-ordinated process of rehabilitation which involves the provision of those vocational services, e.g. vocational guidance, vocational training and selective placement, designed to enable a disabled person to secure and retain suitable employment.¹

- **Mental retardation**: Sub-average general intellectual functioning which originates during the development period and is associated with impairment in one or more of the following: (a) maturation; (b) learning, and (c) social adjustment.²

- **Disabled person**: An individual whose prospects of securing and retaining suitable employment are substantially reduced as a result of physical or mental impairment.¹

B. Magnitude of mental retardation in Costa Rica

(a) **Some socio-economic indicators**

Costa Rica has an area of 51,100 km², a population of 2,000,000, a density of 39 inhabitants/km², and a per capita income of US$1,040.00.

Indians, Europeans, Caribbeans and Asiatics constitute the fundamental ethnic groups which have been mixing increasingly since independence in 1851.

Raw materials are the principal exports, including coffee, bananas, meat and cocoa.

The working population is distributed by the following economic sectors: 40 per cent agriculture and cattle raising, 40 per cent services and 20 per cent industry.

In 1949 Costa Rica abolished all its armed forces. This circumstance made possible the assignment of growing financial resources to the development of social services. Now, 80 per cent
of the population is covered by the government health service; education absorbs more than 30 per cent of the national budget; and social security includes around 70 per cent of the population.

(b) Causes of disability
The causative factors of disability are:

1. Disease and other medical factors which cause retardation of the individual.
2. Environmental factors (climate, unhealthy work conditions, etc.).
3. Attitudes and other socio-cultural determinants.
4. Social demands (closely related to the level of expectation, which varies greatly in different communities and societies).

(c) Profile of the disabled
As in most other countries, Costa Rica does not have reliable statistical data about disability. The National Council for Rehabilitation and Special Education estimates the following profile of disabled persons in active life:

- Around 70,000 need some service of rehabilitation.
- Some 15,000 need vocational rehabilitation services, and of these over 8,000 are mentally ill or retarded.
- The majority are men.
- There are 80,000 alcoholics (both sexes).
- Less than 5 per cent have some kind of vocational training or certification.
- More than 30 per cent are illiterate.
- Over 30 per cent are excluded from the health and social security systems.
- Among the blind, only 10 per cent of the men and 2 per cent of the women have a regular salary.
- Five to 7 per cent of the general population (147,000 inhabitants) present some grade of mental retardation. Some 27 per cent (13,024) of the children of the metropolitan area have some learning problems.

C. Development of rehabilitation
The Costa Rican Government has developed rehabilitation services according to traditional patterns:

(a) It began with the establishment of services of physical medicine and rehabilitation in general hospitals. In 1977 the
National Rehabilitation Centre was inaugurated with 100 beds and 500 ambulatory patients; it is one of the most sophisticated in Latin America.

The Costa Rican Social Security and National Insurance Institute provide these services.

(b) Social rehabilitation services were designed to provide care and economic support for the victims of labour accidents and diseases, and recently began to benefit indigents too. These services are provided through the two institutions mentioned above.

(c) Educational rehabilitation now involves 3,000 physically disabled young people (most of whom are mentally retarded), under the Department of Special Education in the Ministry of Public Education. This programme has three special education centres, located in the main cities. A large number of the pupils are in special classes or integrated in regular primary, secondary and superior schools (for example, ten blind university students graduated from these centres).

(d) Vocational rehabilitation is the only phase not assumed by the Government although it finances 90 per cent of the 1978 budget (see Annex A).

D. Disability prevention

Prevention of disability is the major function of the Ministry of Health. It began by diminishing or eradicating the main infectious diseases through specific programmes which have been quite successful (see Annex A).

E. Staff training and public education

In 1976 the National Council for Rehabilitation and Special Education gave first priority to the training of personnel for rehabilitation programmes. Assessed by an ILO expert in vocational rehabilitation, the Council organised the following with ILO, the University of Costa Rica, the Ministries of Education, Labour, Social Security, and other organisations:

(a) the first Seminar on Comprehensive Rehabilitation of Disabled Persons was presented. It was designed for general directors and staff of ministries, public and private organisations involved with or of major interest to the disabled, including employer chambers and labour unions. Attended by 70 people, the national and international experts succeeded in informing the political decision centres about the countrywide dimensions of disability, and in motivating them to search for feasible solutions.

(b) Subsequently, 6 courses of 400 hours each (4 of which emphasised the vocational component) trained more than 100 professional people working in rehabilitation facilities, i.e. doctors, nurses, psychologists, sociologists, teachers, training instructors, social workers, therapists, selective placement officers and executive directors.
(c) Other activities draw attention to mental retardation, such as the Week of Rehabilitation and Special Education (approved by law and organised every year in November), seminars, conferences, general information by television and all news media communication systems.

(d) Also, our two universities have begun specialised courses for the training of personnel in the fields of rehabilitation and special education.

F. National vocational rehabilitation programme

The programme is fundamentally based in four institutions:

(a) National Council for Rehabilitation and Special Education

Created by law in 1973, by recommendation of the ILO, it is an official co-ordinating body, made up of the 12 most important organisations and sectors of interest for the disabled, including the Ministries of Health, Education, Labour, and Social Security (see Annex A). The National Council for Rehabilitation and Special Education has been very successful in the orientation of national and international resources for the vocational rehabilitation of mentally retarded individuals. In 1976 it defined a successful strategy in the field of vocational rehabilitation:

1. Requested one-year expert assistance from the ILO.

2. Prepared a national programme on vocational rehabilitation which tried to present a profile of disabled people in Costa Rica.

3. Evaluated the existing institutional structures, programmes and achievements on rehabilitation in the country.

4. Defined the goals and designed five specific projects: the training of personnel, a Vocational Rehabilitation Institute, a Selective Placement Unit of the National Employment Service, sheltered workshops for vocational rehabilitation of mentally retarded people, and technical and financial international co-operation.

(b) Vocational Rehabilitation Institute

Assessed by the ILO, the Vocational Rehabilitation Institute belongs to the Costa Rica Goodwill Industries Association, a private organisation. It is a pilot centre with 300 permanent places for physically and mentally disabled people of both sexes. The area includes 15,000 m² of construction. The cost reached one million US dollars and finances were given mainly by the Federal Republic of Germany and Holland.

The budget for 1978 is US$500,000, of which 90 per cent is supported by the Costa Rican Government. The personnel were prepared through basic courses of vocational rehabilitation to better accomplish the main purposes of the centre:
1. Vocational rehabilitation for a permanent population of 200 disabled.
2. Sheltered employment for 100 people.
3. Regional research and training centre for Latin American specialists.

The structure and organisation of the Institute is shown in Annex B. There are written plans and programmes for rehabilitation and sheltered employment.

The basic vocational rehabilitation methodology for the mentally retarded and all other disabled is:

1. Referrals by institutions or individuals.
2. A medical and psychological diagnosis for external services.
3. Assessment for one month in the centre. Each client is observed individually in this order: social worker, executive director, doctor, psychologist, therapist, nurse, selective placement officer, and vocational training instructors.

Then the executive director or the co-ordinator with the participation of all these specialists meets with the client, who is the most important member of the team.

4. Remedial education, if necessary, by special education teachers from assessment until employment.
5. Training in vocational courses programmed, supervised, and certified by the National Institute of Apprenticeship.
6. Employment (in competitive and sheltered programmes) and follow-up services by the selective placement officer.

Admission is free of charge for any disabled person over 15 years of age. The centre has supportive services such as transportation, meals (breakfast, lunch and afternoon snack), fellowships, volunteer workers, and a parental organisation. There are no dormitories. The work schedule is from 8 a.m. to 4 p.m., 40 hours a week, Monday through Friday. There is an annual vacation of one month. Since 1971 Costa Rica Goodwill Industries Association helped 180 mentally retarded people (110 men and 70 women). About 40 individuals graduated from courses in electronics, crafts, industrial sewing and some lesser-skilled activities. The majority of the 180 have been integrated into positions of gainful employment, and about 30 are in the centre's sheltered workshop. Around 500 mentally retarded people receive some kind of vocational rehabilitation service in the occupational therapy department of the Psychiatric Hospital, in the pre-vocational workshops of the Ministry of Education, and in three other private organisations.

(c) National Institute of Apprenticeship

The National Institute of Apprenticeship is the official agency in charge of training normal adults, and offers more than 100 different courses.
Its co-operation with the Vocational Rehabilitation Institute began with the assessment of the design of workshops, but followed by the concession of programmes and instructors. In 1978 the two organisations signed an agreement which in the future would transfer all the technical, administrative and financial responsibility for the training of the disabled (including mentally retarded) to the National Institute of Apprenticeship.

The five years of successful experience we have had in this growing co-operation is the national solution for the training of the mentally retarded in normal programmes for adults.

Next month this institution will initiate a special one-year programme at a cost of US$550,000 for vocational training of the physically, mentally and socially disabled (convicts, alcoholics and prostitutes), co-ordinated with the Vocational Rehabilitation Institute, the National Institute of Alcoholism and other institutions for the disabled.

(d) **Ministry of Labour and Social Security**

A Selective Placement Unit within the National Employment Service was created in 1976. This includes positions for three selective placement officers, but so far only one position has been filled. The National Council of Rehabilitation and Special Education has offered to finance a one-year operation of the Unit with five full-time employees.

G. **Social and vocational reintegration problems**

Social attitudes towards mentally retarded people frequently are affected by ignorance, segregation and fear.

Family attitudes are affected also by poor social and economic conditions that sometimes reflect over-protection, shame or rejection.

Employers accept mentally retarded workers with normal behaviour in the working environment, but they refuse to accept those who are "different" or severely disabled.

Up till now labour legislation has no measures to facilitate job positions of the mentally retarded. However, pensioned handicapped persons may work in individual enterprises.

H. **Plans for the future**

First, we must change the philosophy of rehabilitation. Family, society, experts and governments must help the disabled to be satisfied and content by not limiting their actions only to the re-establishment of disabled individual's capabilities or merely "making him useful". A human being is much more than speech, walking, seeing or thinking.

Secondly, we must transfer to the Government the technical, administrative and financial responsibilities of rehabilitation. Rehabilitation is a branch of science and not a charitable activity. However, this does not exclude private organisations from pioneering and supporting services.
The National Council for Rehabilitation and Special Education will give priority to the rehabilitation of the mentally retarded and the blind in the future. It will promote their training and employment in normal or in special conditions (when necessary, sheltered workshops and/or competitive work for the disabled) where these individuals will be able to work with any type of handicap and with non-disabled workers as well.


Annex A

INSTITUTIONAL ORGANIZATION OF DISABILITY PREVENTION AND REHABILITATION IN COSTA RICA

SERVICES

NATIONAL COUNCIL MEMBERS

- MINISTRY OF HEALTH
- NATIONAL INSURANCE INSTITUTE
- COSTA RICAN SOCIAL SECURITY
- MINISTRY OF EDUCATION
- MINISTRY OF LABOUR AND SOCIAL SECURITY
- NATIONAL INSTITUTE OF APPRENTICESHIP
- VOCATIONAL REHABILITATION INSTITUTE
- PRIVATE ENTERPRISE
- SOCIAL ASSISTANCE INSTITUTE
- ASSOCIATION OF SOCIAL WORKERS
- ASSOCIATION OF PARENTS OF EXCEPTIONAL CHILDREN
- UNIVERSITY OF COSTA RICA
Annex C

- National Council for Rehabilitation and Special Education (Coordination)
- Ministry of Labor and Social Security
- National Vocational Rehabilitation Institute
- Vocational Training (Agriculture, Services, and Industry)
- Assessment Follow-Up Services
- Staff Training
- Occupational Therapy
- Psychiatric Hospitals
- Occupational Therapy Services
To this date no official survey has been done to determine the number of mentally retarded individuals in the Island of Grenada. Informal talks with medical doctors and social workers working throughout the island have indicated that mental retardation is fairly widespread.

We are working hard to get training for everyone, but at present there are still adolescents and adult mentally handicapped who are cared for in their homes with poor facilities and some are in homes for the aged.

The Kennedy Home

The Kennedy Home, a small orphanage, is housing 22 mentally/physically retarded children. Fourteen of them receive custodial care and eight of them class-room activities. Every year many children are referred but are sent back home because our facilities can only take care of 22. The question still remains how can we meet the needs of all the handicapped people? Judging from our financial background we need many more years of hard work. We have, however, made our Kennedy Home a training centre for these children, instead of a home where nothing is done. Six of them go to a special school which was opened one year ago.

The school

The school was started in 1976 in the south-east of St. George. The house was given by the Government, together with a quarter acre of land and the salary of one principal, two teachers and two teachers' aids. There is at present a new school building which will be completed in a few more weeks. This building was given to us by the Rotarians of Canada together with the Rotarians of Grenada.

The Association for the Retarded

There is an association in the island which caters for the upkeep of the school. We can surely say we have come a long way since 1974. With government support we will push forward to help those who need us.

Plans for the future

For the International Year of the Child, the Government of Grenada has agreed to do a survey throughout the island on mentally retarded people.

A workshop will be built on the new school compound.
We also have to obtain training facilities for people who are involved with the work of the handicapped. With trained staff we can make steps towards normalisation.
9. Services and programmes for rehabilitation of the mentally retarded in Guyana

by

Miss R. Campbell

Background information

The Co-operative Republic of Guyana is a member of the Commonwealth of Nations, and is located on the north-east shoulder of South America. The Atlantic sea coast stretches for 270 miles and from it the land extends into the interior for 420 miles. Its boundaries meet those of Venezuela in the west, Brazil in the south and Surinam in the east.

<table>
<thead>
<tr>
<th>Area</th>
<th>215,000 km² (83,000 sq. miles)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>826,014 (based on 1970 census)</td>
</tr>
<tr>
<td>Under 15 age group</td>
<td>360,000 (based on 1970 census)</td>
</tr>
</tbody>
</table>

In Guyana, the problem of mental retardation has been receiving attention over the past decade or so, and efforts have been made towards rehabilitating these individuals. Unfortunately, there are no statistics to indicate the true extent of this problem, but during the years 1973-76 145 mentally retarded children were seen at the Georgetown Hospital. (See Appendix I.)

The programmes and services in Guyana for the mentally retarded are provided by both government and private agencies. There are two in the urban area and one in the rural area, but all three are situated in the County of Demerara, thus presenting a problem, i.e. care for those handicapped in the other two counties.

Georgetown:

In 1968 the David Rose School for handicapped children was opened. The aim of the school is to provide these children with learning experience and skills, enabling them to participate in the community and earn a living. There are 29 teachers and 11 aides at this school. Please see table below.

Pupils and staff - David Rose School for Handicapped

<table>
<thead>
<tr>
<th>Section</th>
<th>Pupils</th>
<th>Trained teachers</th>
<th>Specialist teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally retarded</td>
<td>105 (20 are in the workshops)</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Deaf</td>
<td>101</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Blind</td>
<td>10</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Physically handicapped</td>
<td>24</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Other teachers and staff members

Industrial arts - 3
Ceramic - 1
Home economics - 2
Assistant home economics - 2
Agricultural science - 1
Physical education - 1
Nursing welfare officer - 1
Aides - 11

Entrance to the school is gained by referral from doctor, health visitor or teacher. All entrants to the mentally retarded section are seen by a paediatric consultant, Dr. Austin, at his clinic, which is held every Wednesday at the Georgetown Hospital. Following this the head of the Mentally Retarded Section together with the nursing welfare officer will carry out diagnostic testing to determine the present functioning ability of the child as compared with the normal child. The child is then placed in a class according to the results of this test. Method of teaching used once the test has shown the child to be educable or trainable is the stimulation programme for beginners and speech and language perceptual training.

The curriculum of the school is academic and vocational. The mentally retarded pupils are taught simple reading, writing, arithmetic and social education which includes civics, social studies and cultural activities, e.g. dancing, singing and drama. Home economics and agriculture are part of the curriculum. The vocational aspects embody industrial arts, ceramics and handicraft. At periods during the year, sale of work exhibitions are held and the general public get the chance to see what the mentally retarded can do to contribute to the community.

At the sheltered workshop, there are 20 mentally retarded pupils, 3 of these having passed through the school. They are taught skills in woodwork, carpentry, agriculture, cooking, sewing and ceramics to name a few, in an effort to equip them with some skills to enable them to be useful in society. It has been unfortunate that the workshop has lost most of its equipment due to thefts; efforts have been made to replace most of the items. This was a setback for members of the workshop, which we are trying to overcome.

Open employment opportunities are more easily gained for the deaf than for those mentally retarded; this is due mainly to lack of knowledge of the members of the community, which is based on the fear of the unknown. Nevertheless, we have 16 past students in open employment, 12 deaf and 4 mentally retarded.

The Lions Club of Guyana have contributed greatly to the school and only recently handed over two newly-built classrooms and a soundproof audiometric room. Various other public and private organisations have over the years contributed, e.g. Jaycees, Kiwanis Club, banks and private citizens.

There is a Mental Retardation Association whose members endeavour to help the mentally retarded. A parent guidance meeting is held once a month at the school, where parents/guardians meet with class teachers to assess progress of child and discuss problems encountered.
A nursing welfare officer, through the Ministry of Health, is attached to the school. She offers guidance and counselling to parents, looks after school health of the child and treats minor ailments. This officer liaises with the related agencies as the need arises, e.g. hospital clinic, health centres or the Social Welfare Office. Dental service is also given to the children through the Ministry of Health.

Mahaica:

The Mahaica Cheshire Home for Spastic Children was established in 1972 to provide medical and residential care for the spastic and other handicapped children. Funds for the home were initially provided by the Rotary Club of Guyana and furnished by the Business and Professional Women's Club of Guyana. The home is affiliated to the Cheshire Foundation in London, is managed by a committee and receives a subvention from the Ministry of Health.

There are 11 children at this home. Dr. Iram Alii, consultant orthopaedic surgeon, is Chairman of the Committee and provides medical attention for these children.

The home is under the care of one matron (a nurse), one physiotherapist, one cook and four aides. The cook and meals for this institution are provided by the Ministry of Health.

Linden:

In Linden, a centre for handicapped children was opened in 1975 through the efforts of the Adventist Dorcas Organisation, firms, organisations and private individuals.

This centre provides day care facilities for 40 handicapped children ranging from 5 to 18+ years of age, and is governed by a management board. The children are taught art, craft, cooking and gardening, under the supervision of one matron (a nurse) and four aides. They do swimming as part of their rehabilitation.

To date, four handicapped children from this centre have gained employment in Linden and Georgetown.

Other facilities

On Ward 2 of the Georgetown Hospital there are eight physically/mentally handicapped children who were abandoned there by their parents. Only one of these is of trainable ability and she attends the David Rose School. The other handicapped children's basic needs are met by nurses who care for them at the hospital.

The Home of Angels is a registered organisation committed to building a home for the severely mentally retarded. Although it has been established since 1972, no positive breakthrough has been made to date. This is mainly due to firstly financial constraints and secondly the reluctance of this organisation to integrate with existing facilities offered. Many meetings and correspondence have taken place between Mr. John Harrison - head of this organisation - and the Ministry of Health. To date no concrete proposals have been
made, but the nucleus of the organisation remains the same, holding monthly meetings and fund-raising activities with the hope that eventually this project will become a reality.

Problems related to the social and vocational reintegration of the mentally retarded

1. Lack of public awareness with regard to the potential of mentally retarded children.
2. Inadequate parent involvement in the welfare of their child.
4. High rate of unemployment in country.
5. Very limited industrial development. (Guyana being mainly an agrarian country, the mentally retarded can take part in agriculture to a point, their physical ability being limited.)
6. Limited vocational training institution in the country, minimising the integration of mentally retarded in training schemes.

Future plans

In Guyana, the Government's policy is education for all citizens. In keeping with this, a survey of the extent of mental retardation and handicap is to be carried out; based on the results, future plans will then be made.
### Appendix 1

**Causes of mental handicap**

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiopathic</td>
<td>35</td>
<td>24.1</td>
</tr>
<tr>
<td>Down's Syndrome</td>
<td>17</td>
<td>11.7</td>
</tr>
<tr>
<td>Perinatal</td>
<td>17</td>
<td>11.7</td>
</tr>
<tr>
<td>Prematurity</td>
<td>16</td>
<td>11.0</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>13</td>
<td>8.9</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>12</td>
<td>8.2</td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td>9</td>
<td>6.2</td>
</tr>
<tr>
<td>Meningitis</td>
<td>7</td>
<td>4.8</td>
</tr>
<tr>
<td>Rubella</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>Microcephaly</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Jaundice</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Hypoglycaemia</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Marfan's</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Hypoparathyroidism</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Head injury</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>145</strong></td>
<td></td>
</tr>
</tbody>
</table>
10. Rehabilitation of the mentally retarded in Haiti
by
Miss G. Wolff

Haiti lies on the western side of the Republic of Santo Domingo and has a population of 6 million people. The problem of mental retardation was first handled by a religious organisation, the School of St. Vincent, but only daily care was provided for the clients. It was not until the establishment of the AHRH (Haitian Association for the Rehabilitation of the Handicapped) that vocational services for the retarded were started. As a result of the concern of the AHRH, the CES (Centre of Special Education) was founded in 1975 which is now the main centre for vocational rehabilitation.

There has been no survey in Haiti to determine the number of mentally handicapped people and as far as I am aware, there are no plans to have one done. This is, I think, mainly due to the lack of facilities and the disinterest of Government at this particular time.

After the establishment of CES in 1975, vocational rehabilitation took a step forward in that the Centre of Special Education is comprised of a school for the mentally retarded which has enrolled 70 pupils ranging from ages 3-18. Attached to the school is a workshop for 15 young adults, males and females. The activities at the workshop consist of pottery, weaving, lamp shades, caning chairs, and crochet. It is intended that children leaving the school should go to the workshop for training. Last year the third facility of the CES, the clinic, was completed and is now engaged in early detection and stimulation.

In Haiti, as in other developing countries, job opportunities are almost non-existent for the mentally handicapped especially when it is understood that the rate of unemployment is extremely high and will probably get higher if the present situation were to continue. Thus, there are few opportunities for the mentally retarded and possibilities have not been explored.

Special supportive services in health education and special sectors are minimal. In the health sector, a paediatrician attends at the clinic of CES to children between the ages of birth to two years. If a disability is detected in a child, that child is referred for early stimulation - for the amelioration of the child's condition. Also the school is provided with the services of a psychologist for two hours per week and a psychiatrist for one hour per week. With regard to education, at present there is one special school for the mentally retarded and this is inadequate to meet the demands. Plans are in existence for expansion of this facility throughout the country. There is one social worker attached to the CES and her main function is instructing the parents of retarded children in the methods of early stimulation.

The CES is mainly a voluntary body and receives its finances from annual appeals to the public, other charitable organisations, a government grant and sale of antiques donated by the public. It
is interesting to note that the CES was constructed with funds raised from one project, telemarathan. The school has a complement of 8 full-time teachers, 4 stagiaires, 2 part-time teachers, one in pottery and one in music. The director of the school is a specialist in special education. All teachers are paid from the funds of the AHRH. It is hoped that the CES will soon be financially independent of the AHRH. Thanks to the dynamism of the Association of the Pupils' Parents, recently constituted and called "la Chaine", there is a programme of scholarships and donations.

The teachers of the CES are given on-the-job training. They attend seminars and short-term courses. Already some teachers have been trained in behavioural modification psychometrics of task analysis.

Haiti, like all other countries, is replete with unsolved problems and these are mainly concerned with the attitudes of the society in general and the lack of funds to provide the necessary facilities and equipment. The lack of awareness of the public of what mental retardation is and what is to be expected from the mentally retardate poses a serious problem for the social reintegration of the mentally handicapped.

The problem of vocational integration is even greater when one considers that in a population of 6 million there is only one centre that offers any sort of training. Moreover, with high unemployment the possibility of job opportunities is almost non-existent.

Governmental financial help is minimal and the attitude seems to be that the mentally retarded have low priority.

Plans for the future:

(a) securing the services of specialists from Canada and other countries to conduct training sessions for staff;

(b) expansion of the early stimulation programme to other parts of the country;

(c) establishment of centres similar to CES in other parts of the country;

(d) establishment of a research centre that would be opened to students, stagiaires, educators, Haitien specialists and foreigners;

(e) establishment of a pool of educators for the dissemination of information throughout the country.
11. Rehabilitation of the mentally retarded in Jamaica

presented by
Mrs. V.M. Burnett
Mrs. L. Buchanan
Mrs. H.E. Hack
Mr. I.M. Aiken

Introduction

Services for the mentally retarded in Jamaica were pioneered by a voluntary organisation - the Jamaica Association for the Mentally Handicapped Children (JAMHC).

In 1970, the Government began to support the work of the Association by paying teachers' salaries.

In 1973, the Jamaica Council for the Handicapped (JCH) was established whose main function was to co-ordinate the work of the handicapped, advise Government, register handicapped persons and operate a vocational rehabilitation service. The members of the Council are appointed by the Ministry of Social Security and are drawn from Government, voluntary agencies, professionals and unions.

Extent of the problem of mental retardation

Although the Jamaica Council for the Handicapped, which was established in 1973 under the Ministry of Social Security, has been conducting registration of handicapped persons, there is no survey data which will provide prevalence information. Over the last eight years, however, the Jamaica Association for Mentally Handicapped Children has had an average annual registration of 450 to 500 new cases. In addition to this, small surveys have been conducted in communities with children under the age of five using the Denver Developmental Screening Test. This indicates that there is possibly 4 per cent of children with delays in development which may or may not be due to developmental disabilities of some type.

The Ministry of Education has been conducting a survey (during 1978) on the problem of handicap in school children but the results of this are not yet available. It is also planned to conduct a further survey of handicaps in children in the community early in 1979.

Existing vocational rehabilitation and training schemes

School of Hope, operated by the JAMHC provides a comprehensive scheme of schooling and pre-vocational training for mentally retarded children from ages 5 to 18 years. The present enrolment is 160 students with a staff of 14 teachers. At the age of 15, children are transferred to the workshops on a full-time basis. Girls are trained in cookery, sewing, homemaking and personal grooming. The boys' workshop undertakes training in woodwork and metal craft.
The JAMHC provides schooling for the retarded in other widely scattered areas throughout the island. Although it has not been possible to duplicate the pre-vocational activities in operation at the School of Hope, in other parts of the island arrangements have been made in some cases for 15 year olds to be accepted in junior secondary schools or in Jamaica Adult Literacy classes where further training can be provided.

A workshop run by the Association offers employment as well as opportunity for further training to a limited number of adults who have passed through the school and are 18 years old and up. Articles such as salad bowls and servers, tea-trays, breadboards, handbags and soft toys are produced for sale.

Training in copy typing, switchboard operating, simple accounting and other skills is provided for handicapped people including the mentally retarded at the Office Training Centre run by the JCH. Opportunities for vocational rehabilitation are also provided for handicapped persons over the age of 16 through the Rae Town Assessment and Guidance Centre which also comes under the Council.

Open and sheltered employment
opportunities

In Jamaica, as in many other developing countries, there is now a serious lack of new job opportunities in open employment for the able-bodied and more so for the handicapped. Specialised training for the handicapped is comparatively new and many have not been able to benefit as they should. In several instances this has come about as a result of poor basic education, while others are unable to cope with transportation difficulties. The JCH is now considering an on-the-job training scheme which will provide for the temporary attachment of handicapped persons to private firms at the expense of the Council. During this training period prospective employers would be able to assess the work of such workers notwithstanding their disabilities.

Special support services for the retarded - health

There is no special budgetary provision for the detection and treatment of mental retardation, though medical care provided by the Government through hospitals, clinics, etc. is available to everyone.

Residential care for approximately 35 severely mentally retarded and disturbed children is provided at the Bellevue (psychiatric) Hospital and at the Eventide Home (for the aged and indigent). These come under the Ministry of Health and the Ministry of Local Government respectively. The Child Care Division of the Ministry of Social Security is responsible for the care and foster homes of mentally retarded children who are abandoned. At the present time these are not placed in any special homes but are mixed with normal children in places of safety and other children’s homes.

An early stimulation project for pre-school handicapped children was set up in 1975 under the JCH to meet the urgent need
for early detection and early stimulation of children. This project is under the direction of Dr. Thorburn, Vice-Chairman of the Council. Under this scheme, which receives financial aid from Government, child development aides are trained to counsel and train parents of mentally retarded children in the training and development of their children. Approximately 200 children are served in the Kingston and St. Andrew project by a staff of 2 supervisors and 16 child development aides. This year the project was expanded to the parish of St. Catherine by means of a grant from a Dutch organisation.

**Education and social sectors**

In 1974, the Government assumed responsibility for the cost of underwriting special schools, classes, teachers and other facilities for handicapped children which at that time were being provided by the voluntary agencies. Financial assistance is offered by Government to these voluntary agencies who run the various schools for the different types of handicapped. Special education for the mentally retarded is provided almost exclusively by the Jamaica Association for Mentally Handicapped Children which has been in existence since 1956. The Association has approximately 720 school places throughout the island. Most of these are concentrated in the Kingston and St. Andrew area but about one-third of them are in other parts of the island and at the present time only three parishes now do not have special classes or special schools. In recent years the emphasis in special education has been the development of special classes rather than special schools. In all cases the schools and classes are supported by active local associations for the mentally retarded. The JAMHC also provides one residential facility (the Lopez Home) which provides residential accommodation for approximately 55 mentally retarded children between the ages of 6 and 18. Most of the children who live in this home are boarding in order to be able to attend the School of Hope.

The Ministry of Education in its recent Five-Year Development Plan has proposed a fairly comprehensive special education scheme for all handicapped children including the mentally retarded. This will mainly be developed by special classes within the regular school system which will in some instances be in clusters. The initial part of this scheme is being provided by technical assistance and aid from the Netherlands Government.

In 1979, a Diagnostic and Therapeutic Centre for the diagnosis of learning problems will be built at Mico Teacher Training College. This is the next stage in the development of services for handicapped children. In addition to this, Mico Teacher Training College for the last two years, with the assistance of Dutch technical assistance, has commenced a Teacher Training Scheme to train teachers in special education for the mentally retarded, the deaf and the physically handicapped. During this year the course will be expanded to cover learning disabilities and communication and emotional disorders.
Community support for the mentally retarded (non-government organisations, parent groups, etc.)

The JAMHC which was started in 1956 by Mr. Randolph Lopez, has always existed with community support. It has been an active and strong Association. There are branches throughout the island which are mainly responsible for supporting the school services developed by the Association.

Over the past 12 years the students of the College of Arts, Science and Technology have mounted an annual tag drive to raise funds for the Association. In 1977, $10,000 was raised in two days. Regular financial assistance also comes from Coconut Park, a combined venture of the Jamaica Association and the Polio Foundation. This assistance has enabled the Association to pioneer the development of special classes around the island and also to support the residential service provided by the Lopez Home. The Association has also run an Assessment Clinic since 1970 during which mentally retarded children have been seen and assessed and recommended for school placement. This is the only service of this type in Jamaica.

Service clubs such as the Kiwanis and Rotary have assisted the Association in many instances by building special classes attached to regular schools in different parts of the island. The Association has also received assistance from other business and community organisations such as Victoria Mutual Building Society, the Chinses Free Mason Society, and Desnoes and Geddes Limited.

Training specialised staff

Specialised training for persons serving the mentally retarded has only recently received attention. At Mico Teacher Training College the course in special education was commenced in 1976 with the assistance of the Dutch Government as mentioned previously. Continuous in-service training has been conducted by the Principal of the School of Hope for the last three years for all members of staff.

The Early Stimulation Project provides a short-term training (six weeks) for child development aides to be employed on the project. Three courses have been given of this type since 1975.

Members of staff of the Council have also benefited from short workshops put on by the Caribbean Institute on Mental Retardation, ILO fellowships and assistance given by the Partners of the Americas Programme for exposures in North America and through consultants and experts sent from the United States to assist in training in Jamaica.

Unsolved problems

Some of the main problems include:

(1) shortage of trained personnel and lack of training capability;

(2) inadequacy of funds to provide the services that have been planned;
(3) lack of job opportunities in general.

Plans for the future

Five-year development plans have recently been submitted by the agencies for the handicapped to Government. These have not yet been finally approved. Future plans for early stimulation include extension of this service to be island-wide over the next ten years or so.

Similarly in special education the expansion of special classes in the regular school system is envisaged as part of the education plan.

In vocational rehabilitation, plans have been submitted for comprehensive vocational services in the four regions of Jamaica. These include a number of different kinds of vocational services as outlined in the paper by Mr. Leslie.

Increasing efforts must now be made to improve public educational programmes and to get greater involvement of parents particularly in programmes for children.
12. Rehabilitation of the mentally retarded
in the Netherlands Antilles

by

Dr. S. Englehardt
Mr. B. Pardo

A. Size of the problem

It is not possible to give exact figures for the mentally retarded, because not all the children sent to special schools are mentally retarded. In Curacao up to this moment we have 635 persons registered as moderately retarded. This number represents about 0.85 per cent of the population between 0-19 years of age.

B. Training and rehabilitation facilities

There are not many existing vocational rehabilitation and training schemes for the mentally retarded in Curacao. This year the Practical Labour School, in co-operation with the Department of Counselling and Guidance, started a training programme for those who leave special schools. This programme is known in other countries as the "in-between" project. Of this project we have brought along a video tape, and if there is an opportunity we would like to show this tape so you can have a better idea of this programme in Curacao, which is giving very good results. I am working in this project. This video will show us only the group of mildly retarded, the programme for the moderately retarded is similar.

C. Sheltered workshop

The Government has a kind of sheltered workshop which was started in January 1966 on the Dutch pattern, but adapted to the circumstances of our island. In this sheltered workshop there are possibilities for the mentally retarded and for those physically handicapped who are not able to participate in the normal work process.

D. Special supportive services

For special supportive services for the retarded the Government has three departments:

- in the health sector we have a department of health and a clinic (Capriles clinic);
- for education there are several departments such as Department of Educational Counselling and Guidance, special schools, an early stimulation programme and the PBO; and
- in the social sector there is also a department of social affairs.

These departments are not exclusively for the mentally retarded but do provide services for them.
E. Private groups

(i) Parent Association for Mentally Handicapped Children "TOTOLICA"

They are very active and provide for example:
- public education via magazine and TV programmes;
- day-care centre for 20 children; a new building for 48 children is under construction;
- activities such as parties, family days, picnics;
- toy library for parents to borrow educative toys for their children;
- in co-operation with the Caribbean Institute on Mental Retardation organising workshops and seminars;
- working with groups of severely retarded adults (volunteers).

(ii) Association for the Blind provides:
- rehabilitation programmes;
- a new centre (under construction);
- home-teaching.

(iii) Association for the Physically Handicapped provides:
- home visits;
- staff training courses;
- rehabilitation centre (Mgr. Verriet Foundation);
- school for physically handicapped.

(iv) Foundation for the Deaf: this will be founded very soon.

(v) Soon the Curacao Council for the Handicapped will be founded.

F. Training of staff

There is a training programme for teachers who work in the special schools. There has also been a training programme of four months for the home-teachers. And last June there was also a seven-day special education upgrading programme presented by Paul Rosin.
G. Unsolved problems

Naturally there are still a great number of unsolved problems on Curacao. The biggest however are:

(1) the special schools are still too much focused on academics;

(2) acceptance and integration is still a long way ahead of us. More information is needed on how to educate and change the mentality of the public of Curacao. They do not know much about the mentally retarded although we can see that in the last 5 years this mentality has changed a little for the better;

(3) in the sheltered workshop there are several problems, for example:

(a) the money earned by the workers in the sheltered workshop is very little, and therefore not attractive,

(b) we have too few trainers to give guidance to the leaders,

(c) prospective new entrants have to wait too long before they can start work in the sheltered workshop.

H. Plans for the future

- In line with the recommendations of the ILO Caribbean Regional Vocational Rehabilitation Adviser, the Association of Parents (TOTOLICA), in co-operation with the government, is now considering the funding of a Council for the Handicapped to co-ordinate all activities.

- There are plans to build a second sheltered workshop which can also give work to the severely mentally retarded.

- There are plans to integrate the special schools into the normal schools.

- There are plans for upgrading programmes for teachers.

- There are plans to extend the sheltered workshop.

- There are plans to develop a programme (TV) to educate the population of Curacao about retarded people.

So you see, we do have hope for the future.
At the beginning of 1977 it was decided to set up an activity programme for the young adult group at Dunnottar School. This consisted of approximately 8 fairly severely handicapped young adults who had not had the benefit of schooling in their early age and who did not fit readily into the school programme.

In addition to mental handicap one student had cerebral palsy, and one a psychotic disorder, and another suffered from epilepsy.

The group was under the supervision of a teacher, assisted by weekly visits from a volunteer occupational therapist.

Using a donation of EC$25 for materials, various craft work projects were tried and it was found possible to make a number of items, some of which proved saleable.

At the beginning of 1978 the group was expanded to include another group of similar age but a slightly higher level of ability, supervised by another teacher.

The group now numbers approximately 16 students and undertakes bamboo work "stick" manufacture, weaving, rag rug making, shell work, plant propagation and gardening, and macrame work with the assistance of the teachers.

The skills which are possible to develop in the students at the moment are:

- Sawing
- Sanding
- Varnishing
- Gluing
- Simple weaving
- Simple sewing
- Threading
- Watering
- Weeding
- Hoeing
- Digging
- General cultivation

It is hoped to expand this programme in the future and establish it on a more permanent basis in a specially designed workshop.

**Short term**

It is essential that attempts initiated while the children are pupils of Dunnottar School should be continued in the adolescent group to improve their daily living activities so that the young people will fit happily into their home environment. To this end it must be ensured that they can dress, feed, bath, shave and toilet themselves to the best of their ability. If possible they must also be taught to use public transport, do simple marketing and understand money. In addition they should learn the simple skills of homemaking, such as house cleaning and clothes washing.

It should be of great benefit to them to prepare a simple meal of, for example, tea, porridge, bread and jam. It is intended that
students should also assist in the garden and plant propagation which has been started as a fund-raising activity. It is hoped that these activities will have some carry-over into the home situation.

In addition the students will continue with the craft work activities of shell work, bamboo work, threading seeds into necklaces, rag rug making, weaving with palm fronds, and any other simple craft work using easily obtainable local materials. It is hoped that, on discharge, the students will have acquired sufficient skills to be able to complete tasks at home if supplied with materials.

Initially craft items and plant cutting will be prepared for two annual fund-raising events, the May Fair and the Candle-Light Dinner. Special orders will also be filled.

It is hoped that sufficient profit will be made from craft work and plants to pay for some of the materials and to pay each of the students a small sum when tasks are successfully completed. It is stressed, however, that a workshop such as this can never be self-supporting or profitable in the commercial sense.

Long term

In the long term, it is hoped to continue and expand the programme which has already been started. The running of the nursery garden and the possible introduction of a few hens and rabbits for sale, and to enlarge the choice of food available for school lunches.

The students should be trained in the cleaning and maintenance of the school building; for example, in sanding, painting and gardening. It is hoped also to train the students to assist in preparing a meal for the school children.

The craft work activities will continue and it is hoped to start a small shop at Dunnottar similar to that which is run at Golden Hope Hospital, and to supply some of the tourist shops in town.

Should any simple, subcontract work become available, this will be eagerly accepted.

It is hoped to continue contact with students after discharge, and it is suggested that a social club should be started for ex-students who should then be encouraged to return to Dunnottar one evening each month for social and recreational events. It is suggested that two places in the workshop should be kept for testing any students who might be considered for open employment. The workshop environment provides a situation where work tolerance, concentration, conscientiousness, punctuality, manual dexterity, ability to follow verbal directions or written directions, balance and posture, sight, numeracy, dominant-handedness, and co-operative behaviour among other things can be observed and assessed.

It is hoped that unskilled helpers can be trained to keep records but the success will depend on there being sufficient professional staff to set the tests and interpret the results, e.g. psychologist, physiotherapist, occupational therapist and social worker.
Where staff allows, home visits for assessment and continuity should be carried out.

It is suggested that the programme might usefully form part of the training for teachers, nurses, occupational therapist, aides and other professionals.

**Employment difficulties**

The main problem which makes the majority of the students unemployable in the open market is obviously that of low intelligence. This leads to difficulty in following instruction even when an activity is demonstrated. Constant supervision is required in all activities. There is poor attention span and distractability. The majority of the students are clumsy and lack manual dexterity, and in some cases there is a lack of communication and possible comprehension. Many of the students are incapable of travelling to and from school unaided, and some are unable to carry out the normal activities of daily living in dressing and toileting. In some cases the position is further complicated by cerebral palsy, psychosis and epilepsy which requires medication.

In concept, a workshop programme for the mentally handicapped is not experimental as a number of such groups exist in mental hospitals and institutions for the mentally handicapped throughout the developed world. The type of craft work and employment depend on the availability of funds, staff and materials.

In general, in a situation such as St. Lucia, the main problem which must be solved or avoided is that of pressure of numbers. It would be fatally easy to overload the programme with students who could neither be discharged nor progress to any other institution, and must be maintained to retirement age. Apart from placing a severe strain on the budget, this would lead to stagnation in the programme.

The programme should not be too dependent on any one member of staff, particularly if he or she is an "expensive" expatriate on a short-term contract, or a volunteer. Local staff should be trained to take responsibility for the group and inspire enthusiasm to produce new ideas.

In order to keep objectives clear in the minds of workers, and to provide data for future research, a certain amount of paper work and record keeping is desirable.

The primary object of the group is not to make money but to provide stimulating employment which may be profitable. It is intended to help a group of people who would not otherwise be employable. In order to make a real profit the group would have to discard all its more severely handicapped members and limit the exploration of new ideas, and thus defeat many of its own objectives.
14. Rehabilitation of the mentally retarded in St. Vincent

by

Mr. E. Stephens

(a) Extent of the problem of mental retardation

No survey of the mentally retarded has as yet been undertaken in St. Vincent but although there are plans to have this done, there are some reservations because of the distinct possibility that there would be no follow-up and this could result in further disinterest by an already unaccepting society. However, the Society for Mental Retardation has a fair idea of the number of mentally retarded.

(b) Existing vocational rehabilitation and training schemes for the retarded

There are no existing schemes for vocational rehabilitation and training for the retarded. At the Mental Health Centre there was a centre for occupational therapy where patients were taught how to do simple things like sewing mail bags, but this centre has had to be closed for lack of trained supervisory staff.

(c) Open and sheltered employment opportunities

Although opportunities do exist for employment of the retarded, there has been no organised programme. Approaches have been made to several business houses and although the management of these business houses have indicated their willingness to help, there has been no follow-up and therefore it has been left to the Government to create a limited number of jobs, but in a society where unemployment is running at 35 per cent one can quite understand that the mentally retarded will be the forgotten ones.

(d) Special supportive services for the retarded in the health, education and social sectors

Special supportive services in St. Vincent are entirely within the province of the Government with regard to the employment of specialists. It is quite understandable that within limited financial resources the Government has to depend to a large extent on external agencies to provide the services of specialists. The situation as it now exists is that the family doctor, the teacher and the social worker are the people rendering supportive services.

(e) Community support for the mentally retarded (non-governmental organisations, parent groups, etc.)

The society in St. Vincent regards a case of mental retardation as a curse on the family and therefore something to be hidden from the public eye. With this sort of attitude one can understand that it will be difficult to garner the support of the majority of
the community. However, with unprecedented dedication and singleness of purpose, a few enlightened members of the community got together and voluntarily started a small school for children with special needs. The school is financed by fund-raising efforts by this tireless few, a subvention of $500.00 from the Government and funds from overseas friends of the school.

The school has 23 students and the parents of these children have now formed an association.

(f) **Training of specialised staff**

The existing voluntary organisations do not have the funds to finance the training of specialised staff. The Government will send staff for training when this is financed by an external agency. At the moment the specialised staff consists of one Peace Corps volunteer supervisor trained in special education; an assistant supervisor who has just returned from one year's training in Scotland in mental retardation, and one college trained teacher who has been exposed to workshops in Grenada, Barbados and St. Lucia. These people are all employed at the School for Children with Special Needs.

(g) **Unsolved problems relating to the social and vocational integration of the retarded**

Because of the fact that it is only in the last four years that any effort has been made to tackle the problem of the mentally retarded, most problems associated with that condition are unsolved.

(h) **Plans for the future**

2. Greater community involvement by mounting a massive public education campaign.
3. Pressurising the Government into allocating more funds.
4. Seeking opportunities for vocational rehabilitation and training.
5. Suggesting to the Government the necessity for appropriate legislation.
6. The inclusion in the curriculum of the Teachers' Training College and the nurses' school a programme for the early detection of the mentally retarded.

I realise that what I have just outlined paints a gloomy picture of the situation in St. Vincent, but I am convinced that with untiring efforts of the dedicated few and an understanding Government, the problems of the mentally retarded in St. Vincent can be reduced.
15. Trinidad and Tobago's programme in the field of rehabilitation of the mentally retarded

by
Mrs. N. Patrick
Miss S. Richardson

In this country there is much room for expansion in the field of rehabilitation. Rehabilitation is centred mainly in two departments at St. Ann's Hospital, the psychiatric hospital in the capital of the islands. These departments are:

(1) the Occupational Therapy Department;
(2) the School for the Mentally Handicapped.

They cater for retarded from all parts of the islands. At St. Ann's there are approximately 100 boys and girls, who are soon to be moved to new, more suitable wards. Plans to improve the service here include the addition of physiotherapy and speech therapy and special training programmes for nurses staffing these wards.

Fifty-eight children aged between 6 to 17 attend the school, of these 25 attend half-day sessions at the Occupational Therapy Department in daily mixed groups of 4 to 6; of these 6 older girls approaching school leaving age attend further sessions for domestic rehabilitation, assessment and training in some skills. A small proportion of these children are psychotic or emotionally disturbed and underperforming.

Sessions consist of modified and graded activities to develop latent potentialities and capabilities and to provide social education to enable the child to function in familiar and unfamiliar surroundings. No formal assessments are made but each child is observed during the activities for abilities and disabilities, concentration, co-operation, ability to follow instructions, verbalisation, use of initiative, relationship with therapist and peers, physical disabilities.

Older mentally retarded adolescents attend the Department full time. Some work in specific areas of the Industrial Unit, while those not yet suitable for industrial therapy are fitted into the school programme, while also having individual projects. The Industrial Unit consists of: woodwork, carpentry, shellwork, basketry, linen weaving, soft toys, jigsaw cutting, assembling and packaging areas. Patients in this Unit are long stay, of varied ages, 17 to 60 plus; a fair proportion of them are mentally retarded. They receive weekly wages graded as to regularity and job performance. Supervision is mainly by craft workers, soon to undergo training to become occupational therapy assistants and who work under an occupational therapist.

A group of mentally retarded adolescents work with a therapist in the Unit. This programme includes work on individual projects and group sessions, mostly preparatory for the Arima Rehabilitation Project in East Trinidad and also managed by St. Ann's. This project is in the early stages with the first group of rehabilitees preparing the building and its environs for occupation, and with
Staff being orientated to the programme. The aim is to provide residential rehabilitation, initially for 40 patients (expanding to 64) and day care for 50 rehabilitees. Each group of rehabilitees having a rehabilitation period of not more than 5 years, the ultimate aim being resettlement in the community. Patients considered for the project are interviewed individually by the rehabilitation team for motivation, suitability for and interest in the project. Those chosen then undergo a period of assessment in the Industrial Therapy Unit.

The project uses agriculture and housekeeping as the basis for rehabilitation. Plans are in hand to include a staff member with training and experience in agriculture and an Industrial Unit. Patients are to share the profits of their produce, hence profit would reflect work performance and provide incentive.

One of the problems of the project at present is the attitude of the residents of the area. Residents see it as a transference of "mad people" from St. Ann's, and at present a community programme is under way to help cultivate better understanding.

Other bodies dealing with the mentally retarded are:

1. A group of volunteers from the St. Vincent de Paul Society, visiting the children at St. Ann's weekly, after having had an orientation period from various staff.

2. Trinidad and Tobago Association for Retarded Children, a voluntary body managing the following:

   North Trinidad - The Lady Hochoy Home accommodating 156 residential and 200 children attending daily, occupational and academic classes. There is a waiting list, the majority for residential care. The Government assists with two-thirds of the expenses.

   South - A school at Harmony Hall, Gasparillo and a Day School at Penal meant to accommodate about 30 children but at present accommodating about 45.

   East - MEBISA, an adolescent boys' training centre, accommodates 60 retarded. Its basis is farming, but problems arise in that the majority of boys at present are incapable of being trained for competitive employment and there is a general lack of support from the parents.

3. School for special children, run by a Roman Catholic organisation, SERVOL, and catering for those with hearing defects, slow learners and the mentally retarded. There are 42 children, half with hearing defects, ages 7 to 16. Children are transferred to and from normal schools and there are 3 teachers, unqualified and paid by the Government, and 1 qualified volunteer. It is planned to include pre-vocational activities on larger premises.

4. Classes in some primary schools.

5. La Jeunesse Tutorials - a private school for slow learners and the mentally retarded run by a qualified teacher. At present there is the problem of lack of further training centres for those of school leaving age.
(6) **Tobago** - The Tobago Council for the Handicapped Children runs a small school for the mentally retarded to which the Ministry of Education and Culture gives a grant from which the school is maintained and the teacher's salary is paid. This teacher is unqualified and the school is able to support another teacher suitably trained. The ages of the children range from 6 to 11.

At present in these islands there is need for more co-ordination between existing services. Rehabilitation here would benefit from the addition or the incorporation of training schemes for the adult mentally retarded in centrally located areas or in some existing programmes for other adults. Placement officers or resettlement officers would also be an asset in forming liaison between employers, rehabilitation teams and rehabilitees.

Expansion of rehabilitation services for the mentally retarded would improve their social acceptability which is an invaluable asset to their rehabilitation in this country.
Vocational rehabilitation of the mentally retarded

This report deals with such subjects as the rights of the retarded to work, the principle of normalisation, pre-vocational preparation, task analysis as a means of training the retarded for daily living and work, widening employment opportunities for the retarded, training of personnel and the role of volunteers. The report will be of help and interest to any country or organisation wishing to develop vocational rehabilitation services for mentally retarded persons.