RESULTS OF THE QUANTITATIVE ASSESSMENT OF THE QUALITY OF A HUMAN SERVICE PROGRAM

Name of Assessed Service(s): [redacted]

Name of Operating Agency, if different from the above:

Address: [redacted]

City: [redacted] State/Province: [redacted] ZIP/Postal Code: [redacted]

Date(s) of Assessment: 6 (Day) 11 (Month) 00 (Year) to 7 (Day) 11 (Month) 00 (Year)

Method of Assessment: ____ PASS __X__ PASSING ____ Combination (Specify)

Assessment Context*: __X__ Practicum Training Assessment, Conducted as Part of a PASS/PASSING Training Workshop held in [redacted] on 6-10 Nov. 2000 (dates)

____ Practice Training Assessment, not Conducted as Part of a PASS/PASSING Training Workshop

____ Self-Assessment by Assessed Service/Agency

____ Official PASS/PASSING Assessment:

____ Invited by Assessed Service/Agency

____ Externally Mandated

This Report is Submitted (check as many as apply):

____ Following a verbal presentation of the asssessment results to service/agency personnel

__X__ Without any verbal presentation (at least to date) of the assessment results

____ As a lengthy detailed report of the assessment findings

____ As a brief summary report of the assessment findings

____ Using a set of individual rating feedback forms

Persons Responsible for the Report (please give full names, degrees, titles, & addresses):

__X__ Report Writer: Susanne Hartfiel: see next page

__X__ Report Editor: Prof. W. Wolfensberger PhD, Syracuse University, Syracuse, NY

__X__ Report Reviewed/Approved by: Darcy Elks: see next page

Degree of Confidentiality That Evaluation Team Members & Assessment Sponsors Must Adhere To (to be filled in by authorized recipient of this report):

____ Not to be Released Under Any Circumstances

____ May be Released ONLY for Restricted Teaching & Illustration Purposes

____ May be Released ONLY if Identifying Names, Dates, Places, & Other Such Data Are Deleted or Disguised

____ May be Released as is to Any Interested Parties

____ Other (Specify) _____

*Reports resulting from any type of assessment other than an official one are typically of lower quality, due to the severe time constraints imposed by most training events, and to the relative inexperience and/or learner role of the person(s) on such practicum teams who record the information for feedback. Services assessed under such conditions are asked to be understanding of this constraint.

PLEASE TURN OVER ▶

Participants in the Assessment

Name	Highest Degree	Team Role	Position/Title	Organization & Address	Phone
Susanne Hartfiel	Diploma, SW, Social Sci.	Team Leader	Visiting Scholar	Training Institute, Syracuse Univ., 800 S. Wilbur Ave., Ste. 3B1, Syracuse, NY 13204	315/473-2978
		Team Report Writer/Editor			
Kathy Ann Rodeheaver	MA Adult Ed.	Team Member	Rehab. Specialist	Keystone Comm. Mental Health	717/232-2080 ext. 128
Richard Zumoff	MS Psychology	Team Member	Associate Agency Dir.	Keystone Residence, 1891 Santa Barbara Dr., Ste. 104, Lancaster, PA, 17601	717/581-8229 ext. 34
		Team Member			
Deb Pritchard		Team Member	Program Director	Family Support Assn., 3544 N. Progress Ave., Harrisburg, PA 17110	717/541-8248
Yvonne Wint		Team Member	Rehab. Specialist	Keystone Service System Farmenton, CT	860/658-5775
Tracey R. Betsill		Team Member	Program Director	Keystone Residence, 940 E. Park Dr., Harrisburg, PA 17111	717/541-8322
		Team Member			
		Team Member			
		Team Member			
		Team Member			
		Team Member			
		Team Member			
		Team Member			
		Participant Observer			
		Participant Observer			
		Participant Observer			
Darcy Elks	M.E.d.	Consultant ("Floater") if any	Trainer	1282 Estate Dr. W. Chester, PA 19380	610/918-3465

TABLE OF CONTENTS

RESUMÉS OF THE PASSING ASSESSMENT TEAM PARTICIPANTS

Susanne Hartfiel, Team Leader
Diplomas in Social Pedagogics and Social Sciences. Experience includes: Personal Care Worker in nursing home; Recreational Services and Adult Education for people with mental retardation; Personal Care Assistant for handicapped woman; Project Assistant and Project Director in several evaluation projects at Siegen and Bremen University, Germany. Currently Visiting Scholar at the Training Institute for Human Service Planning, Leadership & Change Agentry at Syracuse University, Syracuse, NY.

Kathyann Rodeheaven
BA Psychology; MA Adult Education. 20 years of experience in human services; currently working as a Rehabilitation Specialist and Family Educator at Keystone Community Mental Health.

Richard Zumoff
M.S. Psychology. Currently Associate Agency Director at Keystone Residence in Lancaster, PA, an agency which provides residential services for individuals with mental retardation and/or mental disorders.

Yvonne Wint
35 years experience in human services; currently working as a Rehab Specialist at Key Service System in Farmenton, CT.

Deb Pritchard
18 years of experience in human services. Currently Program Director at Family Support Association, Harrisburg, PA.

Tracey R. Betsill
Program Director within Keystone Residence, supporting four people with mental retardation over the age of 65 who are preparing for retirement and life after work.

CONTEXT OF THE ASSESSMENT

On November 6, 2000, a team of six persons visited and evaluated the service named on the cover of this report. All members of this team were participants in an intensive workshop on the assessment of the Social Role Valorization* quality of human services by means of the PASSING tool, to be described later. This workshop was conducted by Darcy Elks and her associates, and sponsored by Keystone Residence, Lancaster, Pennsylvania.

The participants in the workshop were all workers in a variety of human services (though mostly in mental retardation), and came from many different locales. A list of the members of the team that assessed this service can be found on the back of the cover sheet of this report, and a brief description of their backgrounds preceded this section. This team also visited and assessed one other service as part of its training experience, and additional workshop teams also visited and assessed two services each.

A PASSING assessment is an in-depth evaluation of the quality of a service project, program or even agency. In order to conduct such an assessment, team members must have access to many and varied sources of information about the service, including documentary material on it, interviews with service representatives and others who may have relevant information, and long periods of observation of the program in operation. However, the assessment team spent only six hours at the service site: three hours in a formal inquiry with the program director, and the remaining three hours observing, reviewing individual goals documentation, and spending time with the recipients and workers. The team also was present when service recipients had their meals. While the team which assessed this service engaged in all those activities, if the evaluation had been for real rather than primarily for training purposes, then there would have been even more extensive evidence collection, including more observation of the program.

While the members of the visiting team were novices in the use of the assessment tool, every member had previously completed a three- or four-day Social Role Valorization workshop in which the principles that underly the tool had been taught in great depth.

---

* For an explanation of Social Role Valorization, abbreviated SRV, see the article "An Overview of Social Role Valorization" which is attached to the end of this report as an appendix. There is also an intermediate-length book which is longer than the article, but shorter and more up-to-date than the PASSING Manual. The correct reference for this book is: Wolfensberger, W. (1998). A brief introduction to Social Role Valorization: A high-order concept for addressing the plight of societally devalued people, and for structuring human services (3rd ed.). Syracuse, NY: Training Institute for Human Service Planning, Leadership and Change Agentry (Syracuse University). It is available for purchase from the Training Institute, 230 Euclid Avenue, Syracuse, NY 13244-5130, USA. While the 1983 edition of PASSING embodies this new conceptualization, it still uses the language of normalization, because the new term SRV had not been coined at the time the PASSING manuscript went to the publisher for printing.

OVERVIEW OF RENOVA CENTER

According to an agency handout, [redacted] was started in 1975 as a pilot Community Living Arrangement program, and a few years later was turned into an Intermediate Care Facility for the Mentally Retarded. The agency was started to address families' needs in getting assistance and medical care for their handicapped children within [redacted] County, [redacted] as at that time families were forced to travel great distances in order to obtain necessary services or to visit their children or relatives in institutions that were far away. In 1995 the agency's original name ([redacted]) was changed to [redacted] which, according to agency documents, stands for [redacted]

[redacted] Center was located within the city limits o[redacted]. The facility of the service was built by adding a wing to an existing local nursing home (called "[redacted]"), so that [redacted] was directly connected to the cafeteria of the nursing home. Next to this joint building of the two agencies was another building, run by a third agency, that offered a day program for elderly people. The county prison was across the street. The direct neighbourhood of the three agencies and the prison consisted of a small neighbourhood with townhouses and a working-/middle-class neighbourhood; a business area was about one mile away. Historically, the county's poor house had been located where [redacted] Center and [redacted] are today.

According to the agency handout, the mission of [redacted] is "to help individuals develop to their fullest potential, enhance their quality of life, and ensure their individual rights, in a caring, home-like atmosphere." [redacted] is seen "as a stepping stone for individuals to return to the community whenever possible."

When the team visited, [redacted] served 25 residents within an age range from 9 to 84, with the majority being between ages 30 and 50, but it had recently been decided that children and teenagers under the age of 18 should not be admitted anymore. Other admission criteria were, according to the agency director, that service recipients are (a) severely physically *and* intellectually impaired, (b) not able to walk and (c) in need of "active treatment." However, we observed several people who were able to walk.

Before moving t[redacted]er, most residents lived with their families; some lived in other institutions or a[redacted]. Some had been living a[redacted] since the agency was started 25 years ago, others moved in later.

Most residents slept in 4-bed bedrooms, a few in single-bed bedrooms. The facility also had a kitchen, a "day-room," a nursing-station, bathrooms, offices for staff, a copy-room, storage-rooms and large hallways.

The program operated 24-hours a day, 7 days a week and provided nursing care, medical care with a doctor visiting once a week, different kinds of therapy (e.g. ocupational-, speech-, music-, physical-, pet-therapy), some recreational activities (e.g. TV, bingo, boat-rides, fishing-derby, visits to amusement-parks), religious services with a priest coming in regularly, and other services (e.g., haircuts). Most of these activities took place inside the facility, some outside and usually in groups. According to the director, the

main program emphasis was on service recipients' physical care, while other service activities were secondary to it. When the team visited the service, 13 out of the 25 service recipients spent their whole day at the facility, 8 service recipients went out for a full-day day-program (such as school or pre-vocational training), and 4 service recipients went out for a half-day day-program.

Overall, the ambiance of the service within the building was very much the kind that people associate with hospitals and nursing homes. For instance, the physical setting had many features that were remindful of medical institutions, such as large hallways, the nursing station, multi-bed bedrooms, the kinds of bathrooms that one would find in medical settings, and so on. The setting also had an institutional odor; a few staff wore medical uniforms; a physician came in regularly and, as described above, service recipients were provided with several kinds of "therapy."

At the time of the assessment, the agency employed 48 staff: 45 women and 3 men; 80% full-time, 20% part-time. The estimated yearly staff-turnover was 30%. In addition to the paid staff, the agency tried to recruit volunteers (individuals and groups) by means of a slide show and program-tours. Volunteers were asked to visit and help conduct activities inside the facility, such as pet-therapy or bingo-sessions, or help conduct group excursions outside the facility. According to the director, the agency had 5 or 6 regular volunteers and several irregular ones.

THE ASSESSMENT METHOD

Below is a description of the assessment tool and the assessment process.

The Assessment Tool

The method of service assessment being applied to the service was the PASSING technique (Wolfensberger, W., & Thomas, S. [1983]. PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals): Normalization criteria and ratings manual (2nd ed.). Toronto: National Institute on Mental Retardation).

PASSING is different from all other service quality assessment tools in that it looks at services from a social role perspective. Because the PASSING tool is based on Social Role Valorization (SRV), reports of PASSING assessments tend to interpret a great many issues in terms of the constructs that play a major part in SRV. Very prominent among these is social role discourse, possibly including the interpretation of the people served in various deviancy roles, as well as past, present or potential future social roles that are positively valued. This discourse helps one think more clearly about what the roles are of service recipients, how the negativity of any of their societally devalued roles could be diminished, how social value might be added to the roles that they hold, and/or how they might be helped to become ensconced in social roles that are positively valued (or at least less devalued) in society.

Further, it is crucially important to understand that PASSING measures service quality from the perspective of what is needed by the people who are being served--i.e., the service recipients--in order for them to fill valued roles in society. Some services have recipients who already hold valued roles and places in society, but also are exposed to

greater-than-average risk of losing these. In such cases, one of the major challenges is usually how to maintain the valued roles of such persons. In other cases, one of the challenges is to recover for such recipients previously-held valued roles, and in yet others, replacing negative roles with positive ones is a major issue.

PASSING does not assess administrative or management issues, but rather focuses solely on programmatic issues. In other words, PASSING users try to step into the shoes of the people who are being served, and to examine whether service practices are good or bad from the perspective of what these people need in order to have valued roles in society. There are all sorts of things that go on in services that are done because of certain laws, historical momentum, decisions that were made by others prior to the arrival of current senior personnel, physical facility features, regulations, resource shortages, what funders require, etc. More often than not, these things are done for nonprogrammatic reasons, and act as constraints on doing what recipients need rather than as facilitators thereof. It is precisely because PASSING looks at service quality *only* from the perspective of the people who receive it that PASSING does not make allowance for the various reasons why service quality may be less than optimal. For example, because of union rules or a shortage of money, a service may not be able to do something for recipients that needs to be done, and therefore quality may be lower. Many such constraints on service quality are not the fault of a service provider; some may even have good rationales behind them. Nor are they irrelevant in terms of understanding the source of a service shortcoming, and the charting of improvements. But this does not change the reality that they may have a less than optimal, or even detrimental, impact on the people who are served. Similarly, PASSING does not make allowance for the fact that some quality-diminishing conditions are unintentional or may even be the result of servers intending to do something helpful. As far as recipients are concerned, unintended problems impact just as severely as intended ones, and may even be more difficult to change.

The appendix, entitled "Overview of PASSING," explains in more detail that PASSING is a quantitative instrument that measures service quality on 42 separate quality elements (i.e., "ratings"), and that each rating is weighted with a certain number of points that represent its contribution (relative to the other ratings) to overall service quality. In other words, more important ratings are more heavily weighted. Some ratings are weighted as high as 50 points, and others as low as 7.

Further, each rating specifies five levels of service quality within the quality domain that the rating addresses. Each of the five levels of each rating is assigned a percentage of the total weight for that rating. Level 1 (representing the poorest service performance in regard to an issue) is weighted with *minus* 100% of the rating weight; Level 2 (representing poor service performance in regard to an issue) is worth *minus* 70% of the rating weight; Level 3 (representing "neutral" performance on an issue) is worth zero; Level 4 (representing positive service performance in regard to an issue) is worth *plus* 70% of the rating weight; and Level 5 (representing the "attainable ideal" of service performance in regard to an issue) is awarded *plus* 100% of the rating weight. Thus, services receive *negative* points for any Level 1 or Level 2 performance on a rating; 0 points for any Level 3 rating performances; and *positive* points for any Level 4 or 5 that they achieve on a rating. Accordingly, the possible total score (i.e., the sum of scores on

all 42 ratings) that a service might achieve on a PASSING assessment ranges from -1000 to +1000. That is, the best a service could do is +1000, and the worst a service could do is -1000.

The so-called "expected" level of performance is +695, which is the sum total of all the next-to-the-best levels (all Level 4s) of performance on all 42 ratings. In other words, services are "expected" to perform clearly positively on each element of PASSING, even when there is still room for additional improvements in each rating area.

A total overall score of zero is called "minimally acceptable," meaning that *taking all 42 ratings into account* (i.e., subtracting any negative scores from any positive ones), the service is doing neither more good than harm, nor more harm than good--at least in overall balance. There may actually be some areas where harm is being done, but these are balanced out by some areas in which the service is making a positive contribution to its clientele.

However, if a total score is less than 0, this means that overall, more harm is done than good, notwithstanding the possibility that some good may also be taking place in some rating areas.

Altogether, PASSING is a demanding instrument that sets very high standards for services. In fact, it compares the practices of a service to an ideal--though one which is practicably attainable. At the same time, any suboptimal scores do not necessarily imply that the service is to blame for the shortcomings. Rather, PASSING simply identifies both the shortcomings and the positive elements of a service, regardless of their cause or source, when or why, or on whose initiative. As mentioned, some of the shortcomings of a service might be due to circumstances that are beyond its control.

The Assessment Process

In many ways, a PASSING assessment that is conducted as part of a PASSING training workshop is the practicum part of a preceding course in Social Role Valorization, since all participants in a PASSING workshop had been to a three- or four-day Social Role Valorization course which taught the principles that underpin the assessment tool. A typical PASSING workshop is a five-day event, and as aforementioned, includes visits and assessments of two practicum sites. In larger PASSING workshops, the participants are divided into several teams of (typically) five to ten members, which means that four, six, eight or more services are assessed, two by each team, with each team being led by a team leader who had acquired the prerequisite skills in earlier PASSING workshops. Also, in most cases, each team leader is supervised by an even yet more experienced person who may be referred to as a "floater" or "senior trainer." Having first met to clarify the sequence of assessment activities, and the roles, responsibilities and expectations for each team member, a team then embarks on the actual PASSING process. (This process follows standardized procedures, laid-out in Wolfensberger, W. [1983]. Guidelines for Evaluators During a PASS, PASSING, or Similar Assessment of Human Service Quality. Toronto: National Institute on Mental Retardation. Assessments which do not follow these procedures may lack validity, or comparability to other PASSING assessments.) The usual schedule of assessment activities is the same for each practicum site, as follows.

The team begins by reading documentary material on the service. Then the team makes a tour of the neighborhood surrounding the service. This tour is typically done by car, but may also involve walking through the neighborhood. The team then conducts a lengthy interview of several hours with people in senior positions in the service, such as the director, supervisors of direct service workers, and sometimes one or more governing board members. The team then observes the program in operation, and if the service is a residential one and conditions permit, has a meal at the service with the residents. (At some day services, the team may also eat a meal with service recipients.) At some point, the team is given a guided tour of both the interior and exterior of the setting, usually while the recipients are there. The team may then peruse additional documentary material, and take the opportunity to talk with other workers and recipients.

After having collected as much information on the service as possible, each team member spends several hours privately reviewing and organizing this information, and making his or her own personal preliminary judgment as to the quality of the service on each of the 42 service quality dimensions ("ratings") assessed by PASSING. After each team member has separately completed this individual determination of performance (i.e., the level) of the service, the team begins a lengthy and intense intra-team discussion on the service as a whole, and on its performance on each of the 42 ratings. This discussion is structured according to a discipline that has evolved over time from earlier evaluation experiences (since 1969), and which is spelled out in the Guidelines mentioned above. It is called "conciliation," and its object is to verify data and observations, weed out faulty interpretations, and--if possible--reach a consensus judgment among all team members as to the performance of the service on each of the 42 rating issues. However, in training assessments, such as this one, if a consensus cannot be attained on a particular rating, then the more experienced team leader has the final say on what the level of the rating should be. Following the Guidelines, the group process is such that in the light of the team's total evidence, individual team members will often be persuaded to change their minds about a quality level that they had previously considered to be the correct one during their private, individual, and preliminary level assignments. It is the team's eventual conciliated judgments that are recorded and reported on the Scoresheet/Overall Service Performance Form, attached to the end of this report.

The conciliation process starts with a lengthy discussion on what the service is, what its purview is, and the identity of the people that it serves: what they are like, what defines them, and what their needs are. In this process, the team is not constrained by what a service claims to be, what its literature says, what its staff say or believe, etc. (PASSING teams are actually privileged in this regard, because so many service workers never have the opportunity to spend as much time looking at the identities and needs of the people they serve in a prolonged *collective* context, and with the aid of a structured problem-solving discipline, as PASSING teams do.) After this, the team discusses and analyzes all of its observations and other information in light of the 42 PASSING ratings. Then the team tries to identify the major overarching issues that the program faces, the major strengths and weaknesses of the service as the team perceived them, and what other noteworthy issues may be, and the recommendations that it would like to offer to the service. The major issues identified by a team may well be ones that sit "above" a service,

so to speak, that may affect a great many specific things that go on in it, and that may also affect other services--maybe even an entire class of services.

A PERSPECTIVE ON THE ASSESSMENT FINDINGS: HOW TO READ THE REPORT

The major emphasis in a PASSING training workshop is to train the participants in the use of PASSING, and in the application of Social Role Valorization. Agencies which serve as practicum sites in connection with such training workshops contribute to the development of more aware and sensitive human service workers and leaders, and thereby hopefully to a general improvement in, or defense of, human service quality overall and in the long run. In return, workshop leaders try to provide some feedback about the service's quality and operations, usually in the form of a written summary of the team's impressions and findings, or a longer report. However, whatever form such feedback takes, it cannot be as extensive, valid, or authoritative as it might be if the assessment had taken place as an officially commissioned evaluation with fully qualified team members, rather than as a training exercise.

Naturally, because this assessment took place within a training context, and because all team members except the team leader were novices to the PASSING tool, we do not feel fully confident of all our findings and recommendations. For instance, since the time spent by the team in collecting data and conducting observations in a training context is necessarily limited, errors in some rating level assignments are practically inevitable. As also spelled out in the aforementioned Guidelines, under non-training conditions, the team would consist of already qualified raters, and the assessment would have been much more exhaustive. Perhaps twice as much (or even more) time would have been spent by the team on site, interviewing service workers and recipients, contacting related agencies and individuals, and extensively reviewing documentation on the service. With this explanation in mind, a service should feel free to attach as much or as little significance to this report and the assessment results shown on the attached Scoresheet/Overall Service Performance Form as it feels they merit.

However, it should also be noted that even training assessments and assessment reports *have* been found in most cases to be fairly accurate in respect to the global score and major subscores, and that repeat or concurrent evaluations by different teams have tended to come up with similar results. Also, some assessment reports have been extensively utilized by the services assessed, usually helping them in their pursuit of improvements, as attested to by follow-up evaluations. Even in the case of weaker assessments and assessment reports, at least some of the team's ratings and conclusions can be assumed to have validity.

As one reads the report and the attached Scoresheet/Overall Service Performance Form, it is almost imperative that one examine the criteria for each rating as spelled out in the PASSING Manual, mentioned earlier, especially in those areas in which a score was obtained that the reader finds surprising. Otherwise, the Scoresheet/Overall Service Performance Form may have little meaning.

The Scoresheet displays the score attained by the service on each of the 42 ratings in the instrument, as well as the scores for each cluster of ratings that is related to a particular topic. The Overall Service Performance Form (on the other side of the Scoresheet) shows the PASSING score received on each of the five subscores of PASSING. The Overall Service Performance Form also notes the context or nature of the assessment. The major issues in the service as identified by the assessment team, and some major recommendations of the team for service improvement, may be listed on the Overall Service Performance Form, or may be discussed at greater length in the text of this report.

Whenever the report makes reference to a specific rating in PASSING, this will be indicated as follows: the rating number, name, and page in the PASSING Manual on which the rating appears, will be given in parentheses following the reference or discussion of the rating in the report. For instance, reference to the beauty of the exterior of the service setting may be followed by the notation: (R1121 External Setting Aesthetics, p. 65).

FINDINGS AND INTERPRETATIONS

Without conciousness of the service recipients' needs, it is impossible to assess the quality of a program. The assessment team spent several hours trying to understand the service recipients' life experiences and identities from an existential perspective, and deducing their needs from these life-experiences and identities. This was done taking into account not only the knowledge the team had about individual service recipients but also the teams' general knowledge about similar people in similar situations.

The next sections are summaries of the teams' understanding of service recipients' identities and needs, followed by a description of the "culturally valued analogue" of [redacted]

A Description of the Life Circumstances of the People Served by [redacted]

We will discuss specifically nine aspects of recipients' identities and life circumstances as the team percieved them.

Impairment as Life-Defining

As already mentioned, all service recipients were severely impaired. For example, most people used wheelchairs and did not communicate verbally; all had limited intellectual capacities; several people had feeding tubes, several had diabetes, several had seizures, and very likely, some people had other health problems as well.

Being so severely impaired means, among other things, the following:
(a) that service recipients depend heavily on other people's support for almost all activities in life, and the quality of this support determines largely their well-being, how they will perceive the world and what kinds of opportunities are afforded to them in life;
(b) that they depend on individualized adaptive equipment; and
(c) that they have to spend much more of their daily time on personal care and other basic things that everybody needs and does, in part just to stay alive.

The team found that being impaired became *the* one overall life defining characteristic for all service recipients, vastly more so than in the case of many other people with impairments. This is the case not only in the terms described above, but also in the way they were perceived by others; perceiving the impairments of the recipients, the other individual characteristics of the recipients largely became invisible to other people. As a result the service recipients' individual goals and desires in life got mostly reduced in the minds of observers to achieving some very minor improvements in just one or two exremely narrow competency domains (e.g., holding a spoon or a cup).

Deindividualization

As service recipients were doing almost everything in life in a group, had very similar belongings, slept in rooms that were very similar and had very similar daily schedules, they could very easily be perceived as members of an apparently homogenous group with its members lacking any individual characteristics, personality, likes, dislikes, interests, feelings and so on.

Loss of Control

If service recipients ever had a little bit of control over their lives, such as, for example being able to influence when and what to eat, when to go to the bathroom, when to sleep, how or with whom to spend their time, which clothes to buy and wear, etc., they lost it entirely. All such and similar descisions were fully taken by others, and no support was offered to enable service recipients to have at least some influence in such personal areas of life, which, by the way, are all things that typical adults in American society take for granted.

Rejection

Another consequence of their condition was, that service recipients got rejected by others because other people tended to focus entirely on the negative aspect of the impairment and tended to feel uncomfortable having them around, maybe not knowing how to communicate, or be, with them.

Isolation and Paid Relationships

Very obvious was also service recipients' isolation and their lack of companions and friends; although some people still got more or less frequent visits from family members, nobody (as far as we were able to determine) had non-handicapped friends. Paid staff saw themselves in the role of a friend or even an "advocate," which means that in service recipients' lives, relationships that normally are freely given got replaced by paid ones.

Segregation, Congregation and Imposition of Devalued Roles

The rejection just mentioned in turn led to segregation, with service recipients spending almost all their time and all of their few activities with other handicapped people, living in a place where society's unwanted people are congregated together in large numbers--historically and presently. Up to one point in their lives, service recipients had been family members, living at home with their parents and sometimes siblings, probably having had at least a few other valued roles besides being a son, daughter, sister or

brother, such as a friend or a church member. The home got replaced by an institution (or several institutions, in cases where people lived in other institutions before moving to [redacted], and the previous valued social roles (if any) got replaced by devalued ones when service recipients became patients, burdens, eternal infants, objects that can be moved around and positioned--to name just a few of their devalued roles. These devalued roles were expressed by a huge number of negative images which surrounded the service recipients.

Impoverishment

Another common life experience for all service recipients was their impoverishment: all had only very little in the way of personal belongings; in fact, all of a person's belongings could be put in just one rather small bin.

Life-Wasting

Another very dominant life experience was the fact that service recipients spent much of their time doing nothing but waiting and dozing. About half of them did not even have a daily occupation outside[redacted]

Likely Impact of Life-Experiences

In the team's opinion, all these experiences must have had a profoundly negative impact on service recipients' identities. For example, being rejected often leads to a feeling of insecurity, unwantedness and worthlessness; segregation, congregation and inactivity lead to a lack of experience in typical environments with typical people, and a lack of opportunities to develop competencies and potentials; inactivity also often leads to a feeling of personal uselessness, and the feeling that there are no prospects in one's life, and that life is not really worth living; the lack of freely given relationships contributes not only to extreme loneliness, but also to strangers getting a lot of influence in one's very personal matters and--if one is handicapped--in all areas of life; basically, life often gets compartmentalized into all kinds of little sections that professionals can work on, and people whose life is compartmentalized in such ways often feel very dependent, lost, and at the mercy of strangers; the lack of valued roles leads people to adapt to the devalued roles they are expected to fill, and to behave as if they really were infants, patients, burdens, objects, etc., especially if these expectations are very strong and if people are not offered any positive alternatives. As it is impossible to be without roles, people go along with negative roles instead of not having any roles at all.

Overall, one can say, that service recipients were not only very impaired, but also very vulnerable on an ongoing basis in many ways. In fact, a lot of what might be seen as a part of their original impairment really might have been created and/or aggravated by their life experiences and life circumstances.

The Needs of the People Served by[redacted]

The list of needs outlined below is not exhaustive, but attempts to provide an overview of the major needs of the service recipients. The team identified the following seven needs as the most important ones and assumed that by addressing these needs, other less important needs will very likely get addressed in the process as well.

1. A place to live. Ideally this would be a real home which gives residents a sense of belonging, stability and safety, and which expresses their personalities and lifestyles. Positive ways to address this need would be, for the children and teenagers among service recipients, a home with their natural parents, and if that is not possible, with a couple or family who replace the natural family (e.g., adoptive or foster parents). For the adults among service recipients, it could be a shared living situation with either family members or with other people they like, who might share common interests. Another aspect of a good home would be that residents would not be isolated within their house or apartment, but would be well connected within the surrounding community, with people coming to visit and with the availability of a wide range of accessible and relevant community resources nearby.

2. Maximally feasible bodily well-being and restoration of health and functioning. Positive ways to address these needs for health and bodily well-being would include, for instance, good personal care and support, through people who know service recipients well and who support them in the long run; good medical care through competent physicians or specialists; individualized adaptive equipment; healthy and tasteful nourishment; and so on.

3. A place in the real world, i.e., belonging, acceptance and valued participation. Positive ways to address these needs would be (a) through friendships and other relationships with valued, non-handicapped people, which are individualized and respectful; (b) through common activities with typical people, that take place in typical places, that are age- and culturally-appropriate as well as meaningful, and in which service recipients fill valued social roles; and (c) through an individualized support system that is committed to a person's growth and adapts to the person's individual way of communication, and that might consist of a combination of family members, friends, neighbours and professionals.

4. Development of individual interests and potentials, as well as being active. Positive ways to adress these needs would be through school, work, activities at home, recreational activities or other meaningful, stimulating and challenging activities, that are age- and culturally-appropriate.

5. Development and expression of a positive unique identity and individuality. Ways to address this need would be, for instance, through service providers efforts to get to know individual service recipients well and understand their individual needs, vulnerabilities, likes, dislikes, interests, wishes for the future, and so on, and to offer activities and support in an individualized fashion; through helping service reipients to project a culturally valued and individual personal appearance, which in turn will help other people to see and treat them as individuals; to help service recipients to acquire a range of age- and culturally-appropriate personal possessions that show who they are; to help service recipients to decorate their own in space in an individualized way, and so on.

6. To the degree that service recipients are able to exercise autonomy and control in a responsible way, the team thought that they need more control over personal matters. A positive way to address this need would be to offer different alternatives to service

recipients, to support them to choose the better alternative while still also protecting people from harmful choices.

7. Being respected by other people. Ways in which this need for respect could be addressed by a service provider are, for instance, by using respectful language to talk with or about recipients, to serve them in a dignifying way, and so on.

The Culturally Valued Analogues of [redacted]

In order to understand what follows, readers have to understand that PASSING judges programs against the so called "culturally valued analogues." A culturally valued analogue is a way of addressing the needs or wants of valued people. It is a way that is usually familiar to most people and viewed by most as positive. It can serve as a model for meeting the needs and wants of societally devalued people and for the recipients of a service for such people. So, based on the inventory of important needs, we now look at how these needs could be addressed in a way that they would likely be addressed, if service recipients were highly valued members of society.

For instance, one of the culturally valued analogues of [redacted] would be a valued household. In such a household a service recipient would live with other people who are highly valued in society. To the degree that help by family members was insufficient, the person would have staff, employed by the family, assigned to him or her. These employees would be paid well, because one would try to keep them for a long period of time; workers would dress well and in turn help the recipient to dress in the most appealing ways in order to project the most positive personal appearance. Prostetic devices would be used in a way that made them as little obvious as possible; and the wheelchair, the recipient would be using, would ressemble an ordinary chair. The recipient would participate as much as possible in the household activities and would get every assistance necessary to participate in activities outside of the home and to interact with the many different valued people who would be part of his or her life. Other members of the household would make sure that the person sees the best phyicians and specialists and receives the best possible medical treatment.

Another culturally valued analogue would be a residential facility with the residents living in apartments that would be furnished like the homes of well-to-do families. The meals that would be provided would be of a similar quality than those in wealthy households. Residents would be treated very well and respectfully and offered a wide range of very individualized services in all areas--inside and outside of their homes-- in which they needed assistance.

Even if living situations as the ones described above were not available, most people would still value an ordinary household and see it as a culturally valued analogue for a facility, such as [redacted] and would generally prefer it over living at [redacted]

The judgement of what the best ways of serving people are, does not imply that the service that gets evaluated has to provide exactly this kind of a service or do all the things described above; but it is important to keep the culturally valued analogues in mind, so that services can come as close to them as possible. All this also implies that in the

following sections [redacted] will not be judged against programs that one would consider being a "good nursing homes" or "good nursing home-like agencies," but against living situations and services that attempt to address recipents' needs in an ideal but still realistic fashion.

Program Strengths and Weaknesses

The following sections will provide a description of the major strengths and weaknesses of [redacted] that emerged from the assessment team's analysis of the program. The sections about strengths and weaknesses will be followed by recommendations.

Program Strengths

The assessment team regrets to report that it was only able to identify a few positive aspects of [redacted] all of them relatively minor strengths compared to the overall weaknesses of the program.

The first asset of [redacted] is the fact that the service is directed at people from the area, trying to prevent them having to move away from the area where they live and where their families live.

Secondly, the team observed some caring staff, who worked hard trying to do as much as they could for individual service recipients in a setting, and within currently existing stuctures, that make it amost impossible to do the right thing, as will be explained shortly.

Thirdly, service recipients' need for day activities outside of [redacted] was recognized by the agency, and the team was told that efforts were being made to advocate for other services to provide support in the area of work or other meaningful day activities.

Fourthly, the agency had recently decided to stop admitting children and teenagers, and to only serve adults. Some of the rationales why the team thought that this is a positive development will be offered below in the section which includes grouping issues.

Fifthly, some of the staff seemed to have a sense of some of the shortcomings of [redacted] which is one of the prerequisites for positive change.

Major Program Weaknesses

This part of the report may be diffcult to read for [redacted] staff, because, as already explained, it is based on very different assumptions about what service recipients' needs are and how they should be addressed, compared to the assumptions on which [redacted] seemed to operate. However, as already mentioned, the assessment team felt that some people working at [redacted] already had a sense of at least some of the shortcomings of the program; so the following sections might be useful to get a clearer understanding of these.

Most of the program weaknesses fell into the category of failure to address service recipients' needs. The following sections explain the needs of the service recipients that

the evaluation team believed were not being met by the program. To a large degree, these shortfalls had something to do with [redacted] functioning as an institution rather than a home.

Institutional environment and practices instead of real homes. As already explained, the assessment team thought that service recipients needed real homes like other people, and not just a place that is "homelike" or that is oriented towards being a good nursing home.

The fact that [redacted] really is not a home but an institution was expressed by a large number of different aspects of the program. For instance, in a real home one would not expect large hallways, staff offices, a copy room, a nursing station or floors totally without carpet (R1132 Internal Setting Appearance Congruity With Culturally Valued Analogue, p. 97). One would not expect 25 people of all ages living together and sharing bedrooms, being served by so many (in this case, 48) staff. In a home, one would not expect virtually all life functions that one would usually engage in *outside* of a home (e.g., medical care, therapy, religious services, haircare and recreational activities) provided within it, but people would go out to get these services or activities elsewhere (R131 Culture-Appropriate Separation of Program Functions, p.243). In a real home, one would not expect people eating in shifts because there is not enough space at the table.

One underlying assumption of the program here seemed to be that *the* one most important thing handicapped people need is nursing care and other kinds of medical treatment (e.g., therapy) within a medicalized setting, while everything else is secondary or not very important for them. This assumption, and the associated practices, also made it clear to everybody (staff, visitors and the service recipients themselves) that handicapped people are very different from everybody else, as they do not seem to need a home like everybody else does, maybe on the assumption that they do not really notice where they are anyway.

Grouping together into one residence such a large number of people, who are already very vulnerable to being perceived negatively, without non-handicapped people who are not staff, conveyed the strong message that handicapped people belong together, are really "better off with their own kind," and should be segregated and congregated (R1231 Image Projection of Intra-Service Client Grouping--Social Value, p.189). Additionally, the high number of residents, and the high number of staff coming and going in shifts, created an enormous complexity for everybody involved; it seemed to make it impossible for service recipients to relate to so many different people and to feel at home. In fact, there were almost no interactions to be seen among residents. For staff, it seemed almost impossible to manage the group in a way that still treated residents as individuals (R2211 Competency-Related Intra-Service Grouping--Size, p. 409).

Grouping handicapped children and adults together violated cultural norms as well, because in American society, only extended families (which are increasingly rare) might show such a big age range, and [redacted] clearly was not a family. One underlying assumption of this age-inappropriate way of grouping might have been that handicapped adults and children are very similar, with the adults maybe being eternal children and the children being as hopeless as the adults. Another assumption might have been that children

with impairments are unable to learn, and therefore grouping them with handicapped adults as models would be alright because not much development would be expected from either. So the messages projected here were that people with impairments are childlike, hopeless and without any potential for learning and development (R1232 Image Projection of Intra-Service Grouping--Age Image, p.199).

The team also found that a [redacted] service recipients lived in an artificial world that deprived them not only of a real home, but also of the opportunity to learn skills that are needed in a home, and in living adaptively with other people in a home, or at least to learn as much in these areas as their individual impairments permit. As already mentioned, it is widely known that people adapt to the environment they live in, and imitate the behaviours of people they live with. This means that [redacted] residents had no positive models for adaptive functioning, insofar as not only all residents were severely handicapped, but the more severely handicapped people were even in the majority, and the less severely handicapped people who might have served as positive models to others were in the minority. Service recipients also did not live in an environment in which skills and behaviours needed in a home could be elicited and strengthened. So all they could do was to adapt to the institution and to the odd ways people in institutions generally behave (R2212 Competency-Related Intra-Service Grouping--Composition, p. 419).

By addressing the need for a home by offering an institution, [redacted] not only contributed to the wounding experience of service recipients, but also perpetuated the long historic tradition of segregation and congregation of handicapped people. Many of the program weaknesses described further below were more or less logical consequences of offering service recipients an institutional environment and practices instead of real homes.

Clinging to an institutional identity seemed to be particularly remarkable in a state such as Pennsylvania, that has moved away from institutions and even from large group homes, and in which there are bound to be many examples of less institutionalized ways of serving people such as those living at [redacted]

Personal care subordinated to agency routines. Although personal care was seen as the most important program activity by staff, the assessment team felt that generally the service practices gave service recipients only relatively basic minimum care. A service providing good personal care in people's homes (and not in a hospital) would be expected, for instance, to care for a service recipient's appearance so that it would be at least consistent with cultural expectations for valued people's personal appearance in American society; efforts would be made that the assistance would be given by people of the same sex, if it included support in very intimate areas; the personal care would be very individualized, and service recipients would get assistance when they need it and hopefully from people who know them well because they stay for a long period of time. All this is especially important with people who can do so little for themselves and are so dependent on other people's support.

In regard to personal appearance, the assessment team found that some service recipients wore typical attire that one would expect for people their age, whereas the

personal appearance of many others showed extreme shortcomings. For instance, it was hard to tell whether some people were men or women because of their attire and haircuts; none of the ladies wore any jewellery or make-up, which a lot of women their age would typically do; many people had bad teeth and it looked as if they had not been to a dentist for a long time; there was no attention paid at all to people's drooling or bad postures; and after having been to the bathroom in the early evening, people sat with only a white sheet wrapped around the lower parts of their bodies. There were no mirrors in which service recipients could see themselves (R141 Program Address of Client Personal Impression Impact, p. 277).

In addition, about half of the service recipients were men while with a few exceptions, most employees were women, who provided very intimate care to these men.

In regard to the program routines, service recipients' individual care seemed very much subordinate to the agency routines, which means that they had to go to the bathroom in shifts, were bathed in shifts, were fed in shifts, etc., and at times when it was on the agency schedule--almost like in a factory, where workers would break tasks into little pieces and finish the same parts of the whole process at a time before proceeding to the next parts of the process. As it takes time to get to know service recipients and their physical needs well in order to adress them in an individualized fashion, the staff turnover was a major obstacle to high quality personal care.

The team found that the low quality care not only had a negative impact on service recipients' physical well-being, but also contributed tremendously to their being negatively perceived by other people, and very probably to their own negative self-image and low competencies as well. For instance, as alluded to before, the poor care in regard to personal appearance made service recipients' impairments seem overwhelming, which means that other people might not even be able to perceive other characteristics of the individual person besides his or her impairment. This in turn will contribute to further rejection, and decreases the likelihood of positive contacts with valued people, because most people do not want to be around somebody in whom they see only characteristics that are widely devalued by society.

The assessment team thought that program routines not only deindividualized service recipients, but also put them in the role of objects handled by staff. Paying no attention to service recipients' sex (i.e. as male or female) made one think that they were seen as totally asexual beings, and it seems very likely that being treated that way will not help to develop adequate identities as men or women (R225 Promotion of Client Socio-Sexual Identity, p. 461).

Open questions about medical care. Very obviously, receiving good medical treatment can be life-defining for people with severe impairments. However, our team found it difficult to evaluate the efforts being made by the agency, because [redacted] staff was very concerned not to give medical information about individual service recipients to team-members. In any case, the agency should make sure that, as much as possible, service recipients' medical needs are properly adressed by competent physicians, specialists and other parties *outside* the service, rather than on site.

One area in which medical treatment was obviously inappropriate was service recipients' dental care, as mentionned above. The team also questionned whether all of the people who had feeding tubes really needed them, and why several service recipients needed so much medication. Both measures might serve to make service recipients' management easier, because certain medications make people quiet, and feeding-tubes can save a lot of time that otherwise would be needed in assisting people in eating normally. Taking into account in what ways service recipients' physical care was subjected to the agency's schedule, these conclusions did not seem to be far-fetched to team members. However, if this is the case, we want to emphasize here that these kinds of "treatment" harm people's health and might even lead to their earlier death, as, for instance, feeding-tubes can cause serious infections, and mind-drugs often have a devastating impact not only on people's minds, but on virtually all vital organs as well.

In addition, the question occured to us whether many recipients were functioning below their capacities due to the drugs they were on.

Group management, and lack of prerequisites for fostering relationships with non-devalued and unpaid people. The need for friendships and other kinds of relationships is one of the most profound human needs and touches every aspect of our lives. For instance, friendships contribute to a sense of meaning and to joy in life; they help people to develop a positive self-image as a person who is liked and loved by others and able to contribute to other people and to society. People with many friendships and other kind of relationships have many more opportunities to be involved in different kinds of activities and to experience new things which, in turn, contributes to the enhancement of their competencies. Particularly important in this case is that people whose friends are valued members of society are much more likely, than those who do not have these kinds of friendships, to be protected from social, physical and emotional harm that quite often is done to handicapped people. Also, people are judged by the company they keep, which means that if they have valued and competent people as their friends, then it is very likely that they themselves are also seen as belonging, as enjoyable to be with, and so on. Therefore it is important that handicapped people have opportunities, and receive active support, to meet people and develop friendships.

Although the agency sees itself as "a stepping stone for individuals to return to the community" and there were some efforts being made by staff to involve residents in activities "in the community," and to recruit volunteers to participate in activities with residents, the assessment team found that the need for contacts and friendships with valued people was not properly adressed [redacted] for the following reasons.

1. First, important prerequisites for the facilitation of positive interactions with valued people were lacking, due to circumstances described below.

a. The assimilation potential of the surrounding neighbourhood was extremely low. Assimilation potential refers to the likelihood that a community and its valued citizens have the capacity to integrate service recipients. Serving a rather large number of people with very obvious impairments, and being located next to the county prison and next to two services for several hundred elderly people who are also devalued by society, [redacted] could not expect the surrounding neighbourhood to be very open to meeting and

getting to know service recipients, because there are simply many more devalued people congregated than the surrounding social systems could integrate (R122 Service-Neighborhood Assimilation Potential, p.175).

b. In addition, the agency was located on a piece of land where historically, society's devalued people have been segregated and congregated in a poor house, and where they are congregated and segregated to this very day, by the prison, [redacted] and [redacted] being so close to each other. So it is very likely that in the minds of a typical [redacted] citizen, the location is seen the way it has been for a long time: as the place where the "others" live, the ones from whom one should keep a distance because they might be sick, dangerous or just very unpleasant to be with (R1152 Image Projection of Setting--History, p. 141 and R121 Image Projection of Program-to- Program Juxtaposition, p. 165).

c. For people in wheelchairs it seemed almost impossible to visit community resources without transportation, even if accompanied by a non-handicapped person: first, the service recipient and his/her visitor would have to use a side- or back-entrance to get out of the facility because the main entrance has steps; secondly, one would have to go around the prison on a street without sidewalks and with rather fast traffic in order to get to the buisness district where one would find some community resources. The assessment team found that, apart from these extreme inconveniences for residents and their visitors, there was the unspoken message that residents should stay where they are (R2111 Setting Accessibility-Clients & Families, p. 345).

d. The facility itself was not very welcoming for visitors. For example, residents could not have guests for dinner because there was simply not enough sitting space for the guests; and the "day-room" where service recipients spent their days was so overcrowded with people in wheelchairs that additional people had a hard time finding a place to sit. Besides that, there were no privacy options in the facility, which meant, for instance, that while the assessment team was there, a mother sat in the entrance hall visiting with her son.

2. Secondly, apart from the lack of prerequisites for positive interactions with valued people, the ways in which the agency tried to involve service recipients with other people was seen as problematic in three ways by the assessment team.

a. Contacts and activities with non-handicapped people were not fostered on an indvidualized basis, so that these might have the chance to get to know an individual service recipient, but always conducted in groups, e.g., with many of the service recipients "going out in the community" together. This had contributed to their rejection by valued community members; for instance, we were told, that residents were not welcomed in the local church any more; in turn, this necessitated bringing more religious activities into the residence.

The agency also invited groups to tour the program, hoping to recruit volunteers, but residents played no positive roles in such tours, as they apparently received no support at all to interact with their visitors in a positive fashion or to participate in showing visitors around. So these program tours did not seem to do much to foster positive interactions

with valued people coming as guests to visit, but may even have put residents in the role of animals in a zoo or circus, who are being viewed or do some performing for the visitors.

b. Additionally, a major part of the activities in which volunteers would be engaged with service recipients must be seen as rather odd and childish by typical citizens, which could create and reinforce volunteers' perception that service recipients are eternal children, different from other people, not able to participate in "real" activities, etc. For instance, when visiting somebody in his or her home one would not expect to have to push adults in a swing, to witness a "parachute-play," or to play bingo with a whole group of people. Typical adults would rarely go to an amusement park or participate in a fishing-derby, or would be more likely to go there with their children if they had any.

c. The agency actively fostered contacts and relationships with other people who are devalued by society. For instance, it engaged service recipients in activities with younger residents from [redacted] thus reinforcing the stereotype that devalued people belong together. As nursing home residents quite often are imaged as being nearly dead or are waiting to die, one can expect that this devastating image will transfer t[redacted] residents as well, because not only did the two groups spend time together but both agencies were located in the same building. Therefore it is very likely that outside observers will percieve both recipient groups as aquivalent. The following observation might exceed the purview of this report, but as [redacted] residents get older and therefore perceived as even more "like" the nursing home residents, ordinary public officials might start to question that there have to be two seperate agencies.

Summing up, it may be said that it is impossible for an agency to be "a stepping stone for individuals to return to the community" if it is outside of the real comunity in a culturally-alien environment with culturally-inappropriate structures and routines, and with people who are excluded from the "community" themselves, because within such structures service recipients will never learn to be "ready" to act appropriately outside of these structures, while people who come from the outside will always have a hard time perceiving them other than in the odd and negative ways the agency presents them.

Inactivity and low expectations. Having meaningful things to do is important for all people, because the kinds of activities we are engaged in will influence the interests and competencies that we develop, which people we will meet, how we perceive ourselves and get perceived by others, and what our place in the world is. Activities in and around a typical home might include things such as the following:

- housekeeping, shopping, cooking, gardening;
- other efforts to make the home nice and comfortable and to let it reflect who the people are that live in there;
- sharing meals together;
- engaging in one's personal interests and hobbies, such as listening to one's music, reading, putting together a photo-album, etc.;
- going out for evening and weekend-activities, for example to sports-events, concerts, movie-theatres, to Church, for a walk, to visit friends or family-members, to participate in a group that is formed around a particular activity;

- having conversations with one's neighbours, and sometimes helping them out with special tasks or by lending items;
- having guests over for dinner or to spend a weekend;
- celebrating feast-days, birthdays and other special events.

Because the service recipients were severely impaired, what they actually can do themselves is limited, but varies from person to person. Nevertheless, a residential service such as [redacted] can be expected to help service recipients to be included and to find their place within such activities. It can also help the people who surround service recipients to perceive their individual gifts and interests, and to find ways to draw on it while doing things together.

The assessment team found that the need for meaningful activities was not addressed by [redacted] because first of all, very few activities were offered; and secondly, those activities that were offered were not very relevant for service recipients because they had little to do with what one would be doing in a home, or what would help service recipients find their places in a real home. This was expressed by the following:

1. Residents spent most of their time in the service being "positioned" in the "day-room", doing nothing, while their minds were being filled with nonsense from the running TV set; additionally, they had to take long mid-day "rests" in their beds, and were gotten ready for bed as early as 8:30 in the evening. This means essentially that their time and life was being wasted, and that competencies they might have had prior to moving into [redacted] Center were very apt to be lost.

2. The program's expectations in regard to individual residents' goals, activities and futures were extremely low, and entirely focussed on improving a very limited aspect of a person's disability, thus putting the disability above everything else. This was expressed in the documentation of residents' individual goals: "Doing goals" meant, for example, that residents should learn things like how to handle a spoon, and were trained in doing so. One could ask, what sense does it make to learn to hold a spoon if a person is deprived from most other positive things that people typically experience in their lives? There might be very little motivation to learn to hold a spoon if it does not lead to something else. In addition, the individual goals documentation of the different service recipients were all very similar.

3. The few activities and routines that were offered by [redacted] were, as already mentioned, mostly very culturally- and age-inappropriate, and thus reinforcing of all kinds of negative stereotypes about service recipients, such as that they were patients, eternal children, objects, worthless and not able to distinguish items of value. For instance, a woman was given an old advertisement section of a newspaper to "read" and when she did not like it she was given some more meaningless newspaper sections--the kind one would put into a reycle bin; or another woman, who was in her 80th, was read from a children's book (R132 Image Projection of Program Activities & Activity Timing, p. 253; R232 Intensity of Activities & Avtivity Timing, p. 485).

Stripping possessions from recipients. Having a certain amount of personal possessions is very important for most people in American society because they contribute

to a feeling of security, and not only in a material sense. Possessions define what people can do in life and which competencies or interests they can develop. People express their identity in part through their possessions in showing others who they are, what roles and positions they occupy in life, and so on. Having a normative amount of valued possessions projects the image that people are valued members of society.

The assessment team found that [redacted] did not address the need for personal possessions; to the contrary, it even contributed to the stripping of possessions from its clientele. For instance, service recipients could bring almost none of their own possessions and furniture when moving into the facility because there was only a very limited amount of space for them. In fact, most service recipients' personal space was reduced to a bed and some wall- and floor-space around this bed, plus a small bin in which all individual belongings should be stored. All the money residents had left for personal expenses was $ 30/month, we were told. Additionally, the agency was legally responsible for the finances of several of its clients, which to the assessment team seemed to involve a conflict of interest.

All residents had only very few possessions, and the ones they were encouraged by the agency to have were mostly infant toys and other items that one would expect children to possess. Most items were of relatively little value. Additionally there was not much difference in different people's possessions: they were all very similar.

The messages given here are that people with impairments are poor, worthless and not able to distinguish items by value, that they are child- or even infant-like, and that they are all the same. The assessment team also found that in stripping possessions from people and replacing these by similar items for everybody, the agency also took away service recipients' personal history and their individual identity, and presented them as an undistinguishable mass of beings--one could say without history and without a real future. Made almost nothing made service recipients even more dependent on the agency than they already were (R142 Image-Related Personal Possessions, p. 287 and R233 Competency-Related Personal Possessions, p. 497).

Mass-management. As handicapped people generally are very much at risk of being deindividualized, the development and expression of the uniqueness of each service recipient should be actively supported by a human service. Many issues of deindividualization have already been addressed; so here are a few additional points.

There were some minor individualization efforts being made by agency-personnel, e.g., one employee spent some time in individual activities with individual service recipients, several staff tried to offer service recipients other kinds of food if they did not like the one that was offered to them in the first place, and the individual goals documentation included a decription of some likes and dislikes of individual service recipients. However, the assessment team found that the deindividualization that service recipients were subjected to was overwhelming. This was expressed by many different aspects of the program, and though most of them have already been mentioned, we list them here in order to emphasize to what degree the deindividualization took place.

1. The physical environment. As already said, most service recipients had no individual private space, and as a consequence, no options for privacy. All bedrooms looked very similar; with very few exceptions, all service recipients slept in the same type of hospital beds; they all had their names posted above their beds in big letters; and the decoration of the wall space above their beds that agency personnel thought to be individualizing also looked extremely similar to outside observers.

2. The agency's schedules and routines. As already mentioned, the daily schedules were much the same for everybody; basic physical care was provided in shifts, service recipients' clothes were purchased twice a year for everybody by designated staff, and so on.

3. Service recipients possessions. The bins in which their personal possessions were stored were identical, except that the owner's names were written on them.

4. Activities. As described above, these were conducted mostly in groups; all service recipients were provided with very similar childlike items and activities; and and when nothing happend, service recipients spent their time in the day room, waiting in a group.

5. Service recipients' individual goals and individual program plans. These were all very similar in that they all focussed entirely on a small aspect of somebody's functional abilities that should be enhanced or maintained. This means basically that all service recipients were expected to have pretty much the same goals for their futures, and these futures were not expected to be very different from the present.

To put it somewhat harshly: considering all the different ways valued people in American society typically live and express their individuality and comparing this with the degree of deindividualization these service recipients had to live with, it can be concluded that they were not seen and treated as individual human beings, but rather as commodities to be mass-managed by a human service agency, and stored in a facility (R215 Individualizing Features of Setting, p. 395 and R224 Program Support for Client Individualization, p. 451).

Control by the agency. People with such severe impairments depend almost entirely on other people from their support system and their circle of friends to understand what their needs, and their vulnerabilities and ways of communication, are, in order to develop a sense of being more in charge over their lifes. This usually takes time and effort, including on the part of servers.

Areas in which service recipients easily could have at least some influence include, for example, when to go to the bathroom or to bed, how and with whom to spend their time, what and when to eat and drink, where to go, and so on.

The assessment team found that being deindividualized in such an enormous way, as described above, also stripped service recipients' lives of almost all occasions in which they actually could experience at least some influence over some aspects of their lifes. The agency controlled virtually every aspect of service recipient's life; service recipients could not even enter all areas within their "home", as there were off-limit areas into which only staff was allowed. As with many other shortcomings we already mentionned, this seemed

to be a quite logical consequence of providing recipients with an institutional environment and institutional practices instead of real homes, because, out of necessity, institutions have to have off-limit areas, since they would not be managable otherwise.

The team also observed several occasions in which service recipients very clearly expressed their discomfort, but staff's only reaction was to make sure that the person stopped bothering other people. The worst of these occasions occured when a service recipient was held down by three or four staff in order to stop him from being physically agressive, and then was left to sit alone somewhere. Among other things, agressiveness quite often is a result of a person's great frustration, and can then be seen as a way of communicating that something is fundamentally wrong in a person's life which the person is not able to expess in a more adaptive fashion, or where nobody responds to the person's other ways of communicating it.

Other negative imagery and multiple devalued social roles. People's welfare depends extensively on the social roles they occupy, which means that people who fill roles that are positively valued by others will generally be afforded the good things in life by them, whereas people who fill roles that are devalued by others will typically get badly treated by them. So a human service should help its recipients to fill as many valued roles as possible, and to reduce the negativity of those devalued roles recipients are yet not able to escape or give up. In any case, human services should not unnecessarily impose negative role expectancies on their recipients if they want them to be perceived and treated positively by other people, and if they want them to learn to act adaptively within valued roles. People can be helped to enter more valued social roles, or value can be added to their already existing roles, by (a) enhancing their competencies that they need to fill these roles, by (b) motivating people to *use* their already existing competencies, and by (c) enhancing their social image. The image issue has been addressed many times before in this report, and is particularly relevant for [redacted] residents, because the less it is possible to convey competencies to people, the more important it becomes to convey positive images about them, so that other people perceive them positively and therefore help them fill valued roles. One of the big contributions of Social Role Valorization has been to clarify this and to bring it into people's consciousness. This also very much explains why in PASSING, there are more ratings concerned with imagery than with competency.

Image messages about service recipients are conveyed, for instance, through the physical environment they live in and its surroundings, through whatever other people they are seen as being associated with, through the activities they are engaged in, through language used to speak to or about them, through their personal possessions, their personal appearance, through an agency's funding sources, program and location names, and so on. Readers might draw parallels with business firms and reflect on what kinds of images these are very routinely trying to project about themselves and their products, in order to show themselves in the most positive light possible.

Although there are roles that can only be filled by people who already have certain competencies, there are also a lot of valued roles that do *not* require a lot of competencies. For instance, service recipients could very well fill roles such as a family

member, a friend, a good neighbour, a church member, a sports fan, a tenant, a music lover, a club member, a customer, a guest, a host, a housemate, and so on.

The assessment team was able to determine only extremely few valued roles that service recipients were still holding, such as being a son or a brother. As already described in the section about the need for non-paid relationships, [redacted] did not do much to support these kinds of valued family roles. In contrast, all service recipients had quite a large range of very devalued roles imposed on them, which was expressed by many aspects of the agency and its programing, and the big amount of negative imagery that surrounded service recipients. Some of them might have been applied largely unconsciously by agency personnel. A few examples follow.

1. The role of "patients," already refered to in the paragraph that described [redacted] and expressed, for instance, through a nursing-station, hospital beds, different kinds of therapy given to service residents, hospital uniforms that some of the staff were wearing, the way staff equated service recipients with their impairments (and called them, for example, "non-verbals", "non-ambs" or "tube-feeders").

2. The role of "eternal children" or "infants," expressed, for instance, through infant toys and wall-decorations, the reading from a children's book and other kinds of activities that one would typically offer to children, but not to adults; and expressed as well through a poem in an agency handout with the title, "Heaven's Very Special Child."

3. The role of "objects," expressed, for instance, through the way people were "positioned" in the "day-room" doing nothing for a long time; or through their management according to the agency's schedule, when being moved around for feeding, getting their food and medication more or less thrown down their feeding-tubes, receiving eardrops or haircuts (during dinner!) or being moved to the bathrooom and gotten ready for bed.

4. The role of a "burden of charity," expressed, for instance, through donation-signs in the hallway or through some of the agency's funding sources.

5. The role of a "menace" who threatens him- or herself and others, expressed, for instance, through physical restraints (a child was sitting with his hands bound together), the holding down by several staff of a man who expressed his anger and discomfort physically, and the consequent warning to team-members that he is dangerous while calling him "little bastard" (by the way, this gentleman was dressed in a way that was remindful of a prison-uniform). As mentioned above, there are many ways to project an image message and a devalued role. Sometimes the explicit verbal formulation can impact much more forcefully on an observer then a message sent by an environment or an activity, which was the case here.

6. The role of "others" or society's outcasts, expressed, for instance, through the agency's location at a place where people who are devalued for different reasons are congregated together; expressed also through the lack of care about people's personal appearance which made them look odd, unpleasant, and made their handicaps more visible

than they ought to be; and expressed as well through the already mentioned poem ("Heaven's Very Special Child").

7. The role of "object of ridicule", expressed through clown-pictures.

8. Death-imaged roles, such as the "nearly-dead" or "better-off-dead." These roles were expressed, for example, through a plaque in the entrance-hall which showed the names of already dead service recipients and very obviously left space for the ones that were going to die; they were also expressed through the proximity to the nursing home which is usually a last place for people before they die; they were expressed through staff using the term "travel boxes" for the equipment in which some residences sat or lay (one might ask where people might travel to in a box if not to their graves?); and through the situation during a fire-alarm, when nobody bothered to help service recipients to get out of the building but staff's first reaction was to leave.

The team found that the ways in which service recipients were presented to other people by the agency, and the expectancies that were held about them, were overwhelmingly negative: who would want to be around such people, or even do something positive for them, if one were not getting paid in doing so? And what alternatives do service recipients have in their situation than to adapt to these negative role-expectancies and start becoming patients, children, objects, menaces or persons who are waiting to die?

Especially when people are cast into multiple devalued roles, one can expect a great deal of harm being done to them; and whenever people are cast into death-roles, one can expect that there are forces at work which threaten and/or shorten their lives.

Disrespect. At this point, it does not seem to be necessary to elaborate in great detail why the assessment team thought that the agency did not address service recipients' need for respect: it is very hard to maintain one's dignity, and to be respected by other people, if one does not have a home, friends, something meaningful to do; sits around with a towel wrapped around when strangers come to visit; gets deindividualized and stripped of one's possessions, has all kinds of negative roles imposed, and can observe one's empty space on the agency's death plaque.

Quite aside from all the other good reasons for fostering respect, there is one particular reason why it is important, which is that if staff can not be sustained in holding respect for the residents, then they will almost unavoidably treat service recipients badly which in turn diminishes their own moral identity. And as experience in human services has shown, this often happens permanently and irreversibly.

Recommendations

The team spent considerable time trying to see how service recipients needs could be effectively addressed. The following recommendations focus only on the most important points which, if implemented, would be very likely to result in positive changes in other areas as well.

On the one hand, we could offer a lot of recommendations of how to make [redacted] a better institution." Some things discussed above already imply what could be

done. For instance, staff could use a more respectful language; residents could be involved in activities that are age- and culturally-appropriate; the wall-decorations that carry negative images could be exchanged for ones that project positive ones; better personal care could be provided; and so on. On the other hand, the team concluded that even with these improvements, the program would still be unsalvagable, which means that most of the recipients' needs could never be addressed within an institutional structure such as [redacted] and a lot of the problems described above would still exist. Probably, such a program would never be able to get a good score at a PASSING evaluation. We therefore recommend to close down the program after having found or created better living arrangements for individual service recipients, and after perhaps having evolved a different mission for the agency.

Whatever the agency descides to do (enhance the quality of the existing program or close down the program and offer another one instead), we suggest the following two measures first.

[redacted] staff and administration should strive to become more conscious and more honest about the social realities that people with impairments face. Consideration of the social realities of having an impairment represents a fundamentally different mindset than the common perspective which locates the problems faced by impaired people solely within the impaired person. Focus on people's impairments alone, and the related unconsciousness of social realities, leads people to de facto blame service recipients for the bad situation they are in, and detoxifies the roles that society, human service agencies and other parties play in creating and maintaining their negative life circumstances. Human service workes quite often believe that they do good things for recipients, even when in fact, the opposite is the case, and they are being used by interests that are clearly not the recipient's. This contributes not only to the oppression of devalued people but also decreases rationality and moral judgement on the part of service workers. It is beyond the scope of this report to offer analysis of the broad societal dynamics of devaluation, of the ways that those dynamics (and other negative ones, such as economic ones) shape service systems and service agencies, and of how the broad dynamics and service patterns commonly have a negative impact on the lifes of devalued people. The team can recommend that service leadership personnel attend Social Role Valorization workshops to study, and then to consider, the reality and impact of societal devaluation. This, in turn, would allow for a better understanding and fuller consideration of the issues described in this report.

2 [redacted] staff and leadership should acknowledge that knowing individual service recipients' backgrounds, identities, needs and vulnerabilities are the most central prerequisites for offering relevant services to people. Therefore, if one wants positive changes to happen, they should be based on an intimate knowledge of individual service recipients.

The sections that follow will deal with descisions to be made by the agency if it decided to close down the currently existing program, and possibly to start a new one.

Generally, all program activities should stay within the purview of a residential service. Purview refers to the scope, or limit of influence, in service recipients' lives that

would generally be perceived as being appropriate for a particular kind of service or agency in order to address recipients' needs. For instance, people would expect a restaurant only to serve food to people, but not also to repair shoes--although the customers might very well have a need for shoe repair as well. Very similarly, a vocational program would not be expected to provide housing, or vice versa.

So, in regard to an agency such a[redacted] the general purview would be to either provide, and/or arrange/mediate for living situations that come as close to the culturally valued analogues as possible.

So if the agency decided to close down the existing program and to start a new one, the following questions would have to be considered, and descisions would have to be taken accordingly.

1. It should be determined which people any new program should serve, what kinds of services would be most relevant to their most pressing needs and should therefore be offered, and in which ways these services should be provided in order to be effective, culturally valued and not harmful.

For instance, the agency would have to decide whether to serve adults, or children, and to what extent their families as well. If it decided to serve children and their families, then the next step would be to determine whether to offer support to already existing families; or the agency could arrange living situations for children who do not have families with whom they can live; or it could do both. Support to families and children might include such things as providing families with information and/or contacts to other people or organisations that might be helpful; providing or arranging for good physical care for the children, if not offered by family members themselves; providing respite for family members; fostering and supporting contacts and relationships for the children with non-handicapped peers and possibly other valued people who might be important in the children's lives; helping the children to develop and exercise personal interests; supporting parents to ensure that their children's schooling needs are properly addressed; and so on. Arranging for living situations for children who do not have families is what a child-placement agency would do, and would include, for instance, finding adoptive or foster parents who are able and willing to provide a good home and good parenting for individual children; matching children and parents well, providing the support necessary to make a placement successful (such as the kinds of support described above) and arranging for safeguards and support in case a placement is not working well.

If the agency decided to serve adults, then it would have to determine whether it wants to offer a program that supports others to provide services (i.e., to arrange for and support individual living situations for service recipients with valued non-handicapped people--which could be family-members, other people who want to share a house or an apartment, a residential cooperative or a community), or if it wants to operate a program or project itself, such as, for instance, small group homes.

Although a single-person household would be consistent with the culturally valued analogue, as many valued people in American society nowadays live alone, the team thought that it would not be an advisable option for current service recipients. Taking into

account their impairments and their consequent dependence on more competent people, living alone would very likely result, first of all, in loneliness and inactivity, as recipients are dependent on other people's support for almost all activities in life, and secondly very likely in failure and/or a lot of harm happening to them, as nobody might be present when the person needed help.

In the first case (i.e., supporting others to provide services), the agency would either have to find already existing agency settings or communities which would be appropriate for individual recipients to live in, and help the person to get settled there; or it would have to offer similar services as described above, such as recruitment and screening of people who would be able and willing to engage in a shared living situation with a person who is handicapped; to match the two (or more) people well; to provide necessary support to make the living situation work well; and to arrange for safeguards, supports and fall-backs in case it is not working.

If the agency wanted to help start a residential cooperative, there would be considerations that have to do with finding the handicapped people who want to live in it, and finding and supporting the group of people who are interested in developing and implementing the project together, which might consist of handicapped people themselves, family members and other interested non-handicapped valued people. The agency's role here would be that of a consultant who would assist the group in clarifying the goals and priorities of the project, and in implementing them one step after the other. For instance, after having developed a clear picture of what the project should be like, the group might need assistance with how to deal with all the issues around finding the right building, or constructing a new one; with where and how to apply for funding; with identifying the needs and necessary supports of individual residents to make the living situation work well for them; with developing a circle of (unpaid and paid) support for individual residents; with the recruitment of the suitable non-handicapped people to live in the cooperative or with a handicapped person; with how to help residents to develop friendships and relationships with other people in the cooperative and in the larger community; with how to get access to relevant community ressources; and so on.

In the second case (i.e., operating a residential project), the agency would have to find the right people to live together, to rent or purchase the right building in the right neighbourhood, and to engage residential staff to provide needed services, such as personal care, support to develop relationships outside the home, and so on.

Whatever service model the agency wants to implement, it might be helpful for leadership personel and staff to visit already existing programs and projects in other places in order to learn about their ways of providing services.

2. After having developed a clear picture of what to offer to which group of recipients and in which ways, then of course those current [redacted] recipients would have to be identified who would *not* be served best by the planned service model, and alternative living situations and support would have to be found for them as well. Therefore, the agency would need to cooperate with other existing agencies in the area that are in a position to provide the needed services.

The last section will discuss some issues that will arise, regardless of which service model(s) the agency might decide to offer.

The first issue is finding valued people who would be interested to get to know, and to be involved with, individual service recipients, even though they do not reside together. A starting point here could be [redacted] staff using their own contacts and friendships to individuals and groups within the community; and to introduce service recipients to, and foster relationships with, these people on an individualized basis.

Instead of recruiting volunteers to serve the agency, volunteers could be encouraged and supported to engage service recipients directly and personally in activities that the volunteers themselves enjoy doing, and to introduce them to their own circles.

Additionally, there should be much more support and encouragement for family members to visit and spend time with their handicapped members; and families who have lost contact to their handicapped members should be encouraged and supported to resume the relationship.

Sometimes, just one meaningful relationship with one person (e.g., being in the valued role of a friend) opens the door to other relationships and to other good things in a person's life. A socially valued person being in an enjoyable and reciprocable relationship with an impaired person in valued contexts and valued settings can often help other people to give up their negative sterotypes, and to see at least this one handicapped person as a person and as similar to themselves in many important ways, even if they still hold negative stereotypes against handicapped people as a class. This means, that such relationships should be (a) freely-given and unpaid, (b) fostered on a one-to-one basis, and (c) take place in valued settings in which other valued people also interact with each other.

Secondly, it is very important that the agency becomes conscious about the images that surround service recipients, and strives to replace negative images by positive ones. As already explained, this is especially important when one tries to get valued people involved with service recipients, and when helping service recipients to enter valued social roles, because people treat other people, and offer opportunities to other people, very much according to how they perceive them, and according to what they hold in their minds about them. Therefore it is important to present service recipients in the most positive--but still realistic--fashion.

Areas that are especially important here are that recipients project a positive personal appearance; that they are seen as being engaged in activities that are culturally valued and appropriate for their ages; that these activities happen in typical places and with valued people who are not staff; and that the language that is used to speak with service recipients or to refer to them is respectful.

Thirdly, the ways in which physical care is offered to service recipients should be reconsidered. As already described, good physical care would not mean to straitjacket a person to an agency's schedule, but would be very indivdualized and would be offered when the person needs it, and as often and as long as the person needs it. It would be offered by people being sensitive to that person and willing to stay for a long time, and

therefore get to know the person well. And if assistance in very intimate areas is needed, it would preferably be provided by people of the same sex.

Of course, at least some support that now is seen as part of recipents' personal care offered by paid staff (such as, for instance, assistance with eating) may not have to be offered by paid staff if the person lived in a shared living situation with other valued and competent people, but might be provided by the people with whom recipients live. So paid staff's time could be spent much more effectively in areas in which services are not offered naturally.

Fourthly, as mentioned, because the best possible maintenance of health is of critical importance for people with such severe impairments, and good medical care can be life-saving, there should be special emphasis in ensuring that recipients medical needs are properly addressed by appropriate parties, and that medical means are *not* used for purposes that are non-medical in nature (such as feeding tubes replacing people taking the time to administer food to somebody naturally).

Fifthly, in case this kind of service is not provided by the people with whom recipients live, service recipients should be helped to acquire a culturally- and age-appropriate amount of possessions. This includes, for instance, that service recipients get support in acquiring and maintaining possessions, and dealing with their finances through somebody who does not have a conflict of interest in doing so; that they have enough personal space in their home to store their possessions in; that they get protected from possession-stripping, and so on.

Sixtly, the agency should continue to advocate for other services to provide adequate services in the area of school, work or meaningful day activities.

And seventhly, the team acknowledges that the kinds of services described above are very challenging work for staff, and it is humanly understandable how attitudes and disciplines might be eroded over time. One of the big contributers to this kind of erosion is that, quite often, human service workers are asked to do the impossible. For instance, the question arose whether [redacted] had unfilled staff slots, or what other reasons there might have been that only relatively few staff were working directly for recipients at the time of the assessment. Quite often one can observe that within agencies and human service systems, there are forces at work that lead to a reduction of time and money spent for direct care staff, in favor of more remote parties or parts of an agency or a human service system, that has much less influence on the close surroundings of the recipients.

So, a major bulwark against such erosion of human attitudes and disciplines is, first of all, constant consciousness-raising and support provided to human service workers; and secondly, to ensure that there is enough staff, so that individual service workers can, in fact, offer good services.

As far as the team could determine, all the recommendations sketched above would be within the purview of the agency, if it chose to redefine itself. They might be hard to implement, and it might mean that the agency would have to renegotiate with funders, but they are all things the agency could do. In fact, other agencies all over the country do exactly these things, and many of them started out pretty much like [redacted]

Global Quantitative Scores

The assessed service received a total PASSING score of -889, which is within the range of "totally inadequate/disastrous." Since PASSING assessments first began to be conducted in 1983, the vast majority of assessed services have attained negative scores, and even among those that have scored positively, not many have scored very high.

In PASSING, there are a variety of sub-scores, broken down by rating areas, as described in the aforementioned appendix to this report, entitled "Overview of PASSING." The assessed service performed as follows on the PASSING subscores:
Program Relevance: "Totally Inadequate" (-50 in the range of -50 to +50).
Program Intensity: "Totally Inadequate" (-175 in the range of -188 to +188).
Program Integrativeness: "Totally Inadequate" (-173 in the range of -217 to +217).
Program Image Protection: "Totally Inadequate" (-298 in the range of -339 to +339).
Program Felicity: "Totally Inadequate" (-193 in the range of -206 to +206).

For a breakdown of the service's score on each rating, please consult the Scoresheet/Overall Service Performance Form, found at the end of the report.

CONCLUSION

People who are familiar with evaluations conducted with PASSING and/or related or similar instruments such as PASS (Wolfensberger, W., & Glenn, L. [1975; reprinted in 1978]. PASS [Program Analysis of Service Systems]: A method for the quantitative evaluation of human services [3rd ed.]. Toronto: National Institute on Mental Retardation) or Model Coherency Impact (Wolfensberger, pilot edition) are aware that reports of such assessments are not always well-received. Recipients of a report may not be familiar with the rationales that underlie such a tool, or--in the case of PASS and PASSING--with its specific ratings and rating clusters; or they may know the rationales, but disagree with them; or recipients may feel that evidence collection by the team, or team expertise, were deficient--and on occasion, this is correct. However, while an assessment by a fully qualified team could be assumed to be competent and accurate, such an assessment is also very expensive.

No matter how this report is accepted, we routinely recommend that persons associated with the service assessed (such as board members, service workers, advisors, sometimes recipients or their families) avail themselves of the opportunity to become more familiar with PASSING and Social Role Valorization, as can be done by reading the PASSING Ratings Manual, as well as other publications. Even better would be to participate in future Social Role Valorization and PASSING workshops.

The team appreciated the cooperation of the servers and recipients at the service, and their patience at having their routines disrupted, and in dealing with a barrage of questions. We very much hope that the findings of the team are helpful to the service, and that some other PASSING team in the future will have a similar opportunity for such a valuable learning experience.

PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals), 2nd Edition, by Wolf Wolfensberger & Susan Thomas

SCORESHEET / OVERALL SERVICE PERFORMANCE FORM

1. Agency Being Assessed: [redacted]

2. Assessment Date(s): 11 (Month) 6 (Day(s)) 00 (Year)

3. The scores on this form show the results of the following type of assessment:

☒ The service of a single-component agency _____ (insert service name if different from that of agency)

☐ One component, namely _____, of a multi-component agency, where this component was:

- ☐ The only component assessed at this time.
- ☐ One of a number of components of the agency assessed at this time, and where the results for other components are shown on separate Scoresheets/Overall Service Performance Forms.
- ☐ Assessment of several components of a multi-component agency: _____

☐ The assessed components were treated and rated as if they were a single unit, so there is only this one Scoresheet/Overall Service Performance Form for all assessed components.

☐ Each of the assessed components was rated separately (with its own Checklist), then their performances were "intellectually consolidated" to render one overall rating shown here.

- ☐ The unconsolidated scores of the various components are each recorded on a separate Scoresheet/Overall Service Performance Form.
- ☐ There is no separate Scoresheet/Overall Service Performance Form for each of the various components assessed.

☐ Each of the assessed components was rated separately (with its own Checklist), then the "budget proportionality" method was used to consolidate the performance of all the separate components into one rating shown here.

- ☐ The unconsolidated scores of the various components are each recorded on a separate Scoresheet/Overall Service Performance Form.
- ☐ There is no separate Scoresheet/Overall Service Performance Form for each of the various components assessed.

4. Brief Statement of General or Overriding Issues:

5. Major Recommendations:

6. Summary of Service Performance (numbers in parentheses represent the range or percentage of achievable scores)

6A. Overall Performance

DESCRIPTION	Totally Inadequate; Disastrous (−100 to ≤ −36%)	Below Acceptable; Poor (≥ −35 to ≤ −11%)	Acceptable; Fair (≥ −10 to ≤ +49%)	Good; Expected (≥ +50 to ≤ +75%)	Excellent (≥ +76 to +100%)
TOTAL PASSING SCORE (range = −1000 to +1000)	(−1000 to −356) **−889**	(−355 to −106)	(−105 to +495)	(+496 to +755)	(+756 to +1000)

6B. By Programmatic Subscore Areas

PROGRAMMATIC SUBSCORE AREAS	Totally Inadequate; Disastrous (−100 to ≤ −36%)	Below Acceptable; Poor (≥ −35 to ≤ −11%)	Acceptable; Fair (≥ −10 to ≤ +49%)	Good; Expected (≥ +50 to ≤ +75%)	Excellent (≥ +76 to +100%)
Relevance (range = −50 to +50)	(−50 to −18) **−50**	(−17 to −6)	(−5 to +25)	(+26 to +38)	(+39 to +50)
Intensity (range = −188 to +188)	(−188 to −68) **−175**	(−67 to −21)	(−20 to +92)	(+93 to +141)	(+142 to +188)
Integrativeness (range = −217 to +217)	(−217 to −78) **−173**	(−77 to −24)	(−23 to +106)	(+107 to +163)	(+164 to +217)
Image Projection (range = −339 to +339)	(−339 to −122) **−298**	(−121 to −37)	(−36 to +166)	(+167 to +254)	(+255 to +339)
Felicity (range = −206 to +206)	(−206 to −74) **−193**	(−73 to −22)	(−21 to +101)	(+102 to +155)	(+156 to +206)

6C. By Rating Areas

TOTAL RANGE OF ATTAINABLE SCORES IN 4 MAJOR SUBDIVISIONS	Ratings Primarily Concerned With Social Image Enhancement					Ratings Primarily Concerned With Personal Competency Enhancement				
	Totally Inadequate; Disastrous (−100 to ≤ −36%)	Below Acceptable; Poor (≥ −35 to ≤ −11%)	Acceptable; Fair (≥ −10 to ≤ +49%)	Good; Expected (≥ +50 to ≤ +75%)	Excellent (≥ +76 to +100%)	Totally Inadequate; Disastrous (−100 to ≤ −36%)	Below Acceptable; Poor (≥ −35 to ≤ −11%)	Acceptable; Fair (≥ −10 to ≤ +49%)	Good; Expected (≥ +50 to ≤ +75%)	Excellent (≥ +76 to +100%)
Physical Setting of Service (range = −329 to +329)	(−171 to −62) **−155**	(−61 to −19)	(−18 to +84)	(+85 to +128)	(+129 to +171)	(−158 to −57) **−114**	(−56 to −17)	(−16 to +77)	(+78 to +118)	(+119 to +158)
	(social image enhancement range = −171 to +171)					(personal competency enhancement range = −158 to +158)				
Service-Structured Groupings & Relationships Among People (range = −369 to +369)	(−146 to −53) **−123**	(−52 to −16)	(−15 to +72)	(+73 to +109)	(+110 to +146)	(−223 to −80) **−197**	(−79 to −25)	(−24 to +109)	(+110 to +167)	(+168 to +223)
	(social image enhancement range = −146 to +146)					(personal competency enhancement range = −223 to +223)				
Service-Structured Activities & Other Uses of Time (range = −188 to +188)	(−81 to −29) **−81**	(−28 to −9)	(−8 to +40)	(+41 to +61)	(+62 to +81)	(−107 to −38) **−107**	(−37 to −12)	(−34 to +52)	(+53 to +80)	(+81 to +107)
	(social image enhancement range = −81 to +81)					(personal competency enhancement range = −107 to +107)				
Miscellaneous Other Service Language, Symbols & Images (range = −114 to +114)	(−114 to −41) **−112**	(−40 to −13)	(−12 to +56)	(+57 to +86)	(+87 to +114)	NOT APPLICABLE- NO RATINGS				
	(social image enhancement range = −114 to +114)									

PASSING SCORESHEET / OVERALL SERVICE PERFORMANCE FORM

-889

TOTAL PASSING SCORE (1000 to - 1000)

1 RATINGS PRIMARILY RELATED TO SOCIAL IMAGE ENHANCEMENT SUBSCORE (- 512 to + 512) -471

2 RATINGS PRIMARILY RELATED TO PERSONAL COMPETENCY ENHANCEMENT SUBSCORE (- 488 to + 488) -418

PHYSICAL SETTING OF SERVICE

11 IMAGE-RELATED PHYSICAL SETTING OF SERVICE SUBSCORE (- 171 to + 171) -155

111 SERVICE-NEIGHBORHOOD HARMONY SUBSCORE (- 34 to + 34) -34

R1111 Setting-Neighborhood Harmony (- 16, - 11, 0, 11, 16) -16

R1112 Program-Neighborhood Harmony (- 18, - 13, 0, 13, 18) -18

112 SETTING AESTHETICS SUBSCORE (- 38 to + 38) -38

R1121 External Setting Aesthetics (- 16, - 11, 0, 11, 16) -16

R1122 Internal Setting Aesthetics (- 22, - 15, 0, 15, 22) -22

113 SETTING APPEARANCE CONGRUITY WITH CULTURALLY VALUED ANALOGUE SUBSCORE (- 36 to + 36) -36

R1131 External Setting Appearance Congruity With Culturally Valued Analogue (- 14, - 10, 0, 10, 14) -14

R1132 Internal Setting Appearance Congruity With Culturally Valued Analogue (- 22, - 15, 0, 15, 22) -22

114 SETTING AGE IMAGE SUBSCORE (- 26 to + 26) -26

R1141 External Setting Age Image (- 10, - 7, 0, 7, 10) -10

R1142 Internal Setting Age Image (- 16, - 11, 0, 11, 16) -16

115 MISCELLANEOUS IMAGE ASPECTS OF THE PHYSICAL SETTING SUBSCORE (- 37 to + 37) -21

R1151 Image Projection of Setting – Physical Proximity (- 16, - 11, 0, 11, 16) 0

R1152 Image Projection of Setting – History (- 7, - 5, 0, 5, 7) -7

R1153 Image Projection of Setting – Other Internal Physical Features (- 14, - 10, 0, 10, 14) -14

21 COMPETENCY-RELATED PHYSICAL SETTING OF SERVICE SUBSCORE (- 158 to + 158) -114

211 SETTING ACCESSIBILITY SUBSCORE (- 58 to + 58) -36

R2111 Setting Accessibility – Clients & Families (- 36, - 25, 0, 25, 36) -36

R2112 Setting Accessibility – Public (- 22, - 15, 0, 15, 22) 0

R212 Availability of Relevant Community Resources (- 22, - 15, 0, 15, 22) 0

R213 Physical Comfort of Setting (- 38, - 27, 0, 27, 38) -38

R214 Challenge/Safety Features of Setting (- 22, - 15, 0, 15, 22) -22

R215 Individualizing Features of Setting (- 18, - 13, 0, 13, 18) -18

SERVICE-STRUCTURED GROUPINGS & RELATIONSHIPS AMONG PEOPLE

12 IMAGE-RELATED SERVICE-STRUCTURED GROUPINGS & RELATIONSHIPS AMONG PEOPLE SUBSCORE (- 146 to + 146) -123

R121 Image Projection of Program-to-Program Juxtaposition (- 12, - 8, 0, 8, 12) -12

R122 Service-Neighborhood Assimilation Potential (- 22, - 15, 0, 15, 22) -22

123 IMAGE PROJECTION OF INTRA-SERVICE CLIENT GROUPING – COMPOSITION SUBSCORE (- 47 to + 47) -47

R1231 Image Projection of Intra-Service Client Grouping – Social Value (- 29, - 20, 0, 20, 29) -29

R1232 Image Projection of Intra-Service Client Grouping – Age Image (- 18, - 13, 0, 13, 18) -18

R124 Image-Related Other Integrative Client Contacts & Personal Relationships (- 29, - 20, 0, 20, 29) -29

125 SERVICE WORKER IMAGE ISSUES SUBSCORE (- 36 to + 36) -13

R1251 Service Worker-Client Image Transfer (- 18, - 13, 0, 13, 18) 0

R1252 Service Worker-Client Image Match (- 18, - 13, 0, 13, 18) -13

22 COMPETENCY-RELATED SERVICE-STRUCTURED GROUPINGS & RELATIONSHIPS AMONG PEOPLE SUBSCORE (- 223 to + 223) -197

221 COMPETENCY-RELATED INTRA-SERVICE CLIENT GROUPING SUBSCORE (- 89 to + 89) -76

R2211 Competency-Related Intra-Service Client Grouping – Size (- 46, - 32, 0, 32, 46) -46

R2212 Competency-Related Intra-Service Client Grouping – Composition (- 43, - 30, 0, 30, 43) -30

R222 Competency-Related Other Integrative Client Contacts & Personal Relationships (- 42, - 29, 0, 29, 42) -42

R223 Life-Enriching Interactions Among Clients, Service Personnel, & Others (- 42, - 29, 0, 29, 42) -29

R224 Program Support for Client Individualization (- 32, - 22, 0, 22, 32) -22

R225 Promotion of Client Socio-Sexual Identity (- 18, - 13, 0, 13, 18) -18

SERVICE-STRUCTURED ACTIVITIES & OTHER USES OF TIME

13 IMAGE-RELATED SERVICE-STRUCTURED ACTIVITIES & OTHER USES OF TIME SUBSCORE (- 81 to + 81) -81

R131 Culture-Appropriate Separation of Program Functions (- 29, - 20, 0, 20, 29) -29

R132 Image Projection of Program Activities & Activity Timing (- 32, - 22, 0, 22, 32) -32

R133 Promotion of Client Autonomy & Rights (- 20, - 14, 0, 14, 20) -20

23 COMPETENCY-RELATED SERVICE-STRUCTURED ACTIVITIES & OTHER USES OF TIME SUBSCORE (- 107 to + 107) -107

R231 Program Address of Clients' Service Needs (- 50, - 35, 0, 35, 50) -50

R232 Intensity of Activities & Efficiency of Time Use (- 39, - 27, 0, 27, 39) -39

R233 Competency-Related Personal Possessions (- 18, - 13, 0, 13, 18) -18

MISCELLANEOUS OTHER SERVICE LANGUAGE, SYMBOLS, & IMAGES

14 IMAGE-RELATED MISCELLANEOUS OTHER SERVICE LANGUAGE, SYMBOLS, & IMAGES SUBSCORE (- 114 to + 114) -112

R141 Program Address of Client Personal Impression Impact (- 32, - 22, 0, 22, 32) -32

R142 Image-Related Personal Possessions (- 25, - 17, 0, 17, 25) -25

143 IMAGE PROJECTION OF LANGUAGE & LABELING PRACTICES SUBSCORE (- 41 to + 41) -41

R1431 Image Projection of Personal Labeling Practices (- 25, - 17, 0, 17, 25) -25

R1432 Agency, Program, Setting, & Location Names (- 16, - 11, 0, 11, 16) -16

R144 Image Projection of Service Funding (- 7, - 5, 0, 5, 7) -5

R145 Image Projection of Miscellaneous Aspects of a Service (- 9, - 6, 0, 6, 9) -9

NOT APPLICABLE - NO RATINGS

MENTAL RETARDATION Vol. 38, No. 2, 105–123, April 2000

A Brief Overview of Social Role Valorization

Wolf Wolfensberger

Abstract: Social roles dominate people's lives, and people largely perceive themselves and each other in terms of their roles. The value people attribute to various social roles tends to decisively shape their behavior toward persons whom they see in valued or devalued roles. Those in valued roles tend to be treated well and those in devalued roles, ill. The most current and recently revised version of the Social Role Valorization (SRV) schema is presented in condensed form, showing how social role theory can be recruited for designing very powerful practical measures to pursue valued roles for mentally retarded and other persons or classes at risk of social or even societal devaluation, to upgrade the perceived value of the roles such persons already occupy, and/or to extricate such persons from devalued roles.

Introduction

Social Role Valorization (SRV) is a high-level and systematic schema, based on social role theory, for addressing the plight of people who are devalued by others, and especially by major sectors of their society. It grew out of the Wolfensberger formulation of the principle of normalization, the most detailed expositions of which are found in Wolfensberger (1972), Wolfensberger and Glenn (1973, 1975), and Flynn and Nitsch (1980). In turn, Wolfensberger's normalization formulation was inspired by Bengt Nirje's (1969) seminal statement of the principle of normalization.

Although the normalization principle became foundational to service practice in mental retardation, and to a lesser extent in other fields, it has been persistently and massively misinterpreted (e.g., Wolfensberger, 1980; see also Flynn & Lemay, 1999). This has been less the case with SRV, and the author hopes that this overview will further clear up misunderstandings, especially as I try to respond to earlier criticisms and incorporate the fruit of deliberations by many people since the first—and until then, only—overview of SRV in this journal was published (Wolfensberger, 1983). Since then, SRV has so much evolved that it can no longer be considered a version of normalization, and much less a renaming thereof.

The key premise of SRV is that people's welfare depends extensively on the social roles they occupy: People who fill roles that are positively valued by others will generally be afforded by the latter the good things of life, but people who fill roles that are devalued by others will typically get badly treated by them. This implies that in the case of people whose life situations are very bad, and whose bad situations are bound up with occupancy of devalued roles, then if the social roles they are seen as occupying can somehow be upgraded in the eyes of perceivers, their life conditions will usually improve, and often dramatically so.

In SRV, there is much discourse about people, their roles, or their social images being valued or devalued by others. To devalue some entity means to attribute low value to it, or less

Editor's Note. This author has a long-standing tradition, explained in his earlier articles in AAMR publications, of not using people-first language. The editor has waived this requirement in this specific instance.—S. J. T.

Un bref survol sur la valorisation des rôles sociaux

W. Wolfensberger

Les rôles sociaux dominent la vie des gens, et ceux-ci se perçoivent grandement eux-mêmes et les autres, en fonction de leurs rôles. La valeur attribuée par les personnes aux différents rôles sociaux tend à façonner de façon décisive leurs comportements envers les gens qu'il perçoivent dans des rôles valorisants ou dévalorisants. Ceux dont les rôles sont perçus comme valorisés ont tendance à être bien traités, alors que ceux dont les rôles sont perçus comme dévalorisés, ne sont pas bien traités. La plus récente version du construit «Valorisation des rôles sociaux» (VRS) est présentée dans sa forme condensée. Elle permet de voir comment la théorie des rôles sociaux peut être utilisée pour mesurer de façon pratique et efficace la poursuite d'un rôle social valorisé chez les personnes présentant un retard mental ou chez les autres personnes à risques de dévaluation sociale ou sociétale, pour augmenter la valeur perçue des rôles que ces personnes occupent présentement, et pour dégager ces personnes de leurs rôles dévalorisés.

value than one attributes to other entities of the same class. When SRV refers to "devalued people," the intent is to convey that people are being perceived and interpreted *by others* as having lesser value than these others see themselves, or most other people, as possessing. This is a value judgment that one may not agree with. However, the social and behavioral theory that is incorporated into SRV is very powerful in informing us, on the one hand, how people become devalued in the eyes of others and what bad things happen to them as a result and, on the other hand, what can be done to maximize the likelihood that by occupying more valued social roles, people will become more valued by others and, consequently, experience improvements in their life conditions.

There is still much discussion within the culture of SRV promotion as to which of many potential formulations of SRV to adopt. However, until a consensus emerges, and for purposes of this brief exposition, suffice it to say that SRV draws on empirical knowledge and social science theory to understand how people's social roles are shaped so as to be positively or negatively valued in the eyes of beholders. Of course, the intent in crafting SRV was as an action scheme for the pursuit of (more) positive roles for socially—or even societally—devalued people and those at risk of such devaluation. The terms *valorizing* and *valorization* refer to the adding of value to something, or the value-upgrading thereof, and are used increasingly in that sense in other contexts as well. In the context of SRV, it is the valorization of social roles that is at issue.

A major corollary of this formulation is that one needs to be clear whose role-valorization of whom one wants to obtain. (In the rest of this paper, I will sometimes use the word *party* when a statement can apply to any two, or all, of the following referents: an individual, a group, or an entire class.) After all, different reference targets may hold different values. This implies that one's role-valorizing actions may have to be different for different reference targets, so as to recruit their values to the role-valorization of some party that had been, or was about to be, devalued by them.

This fact demands many value decisions. However, because by its very nature, science cannot provide answers to value questions (such as whether anyone should hold valued or devalued roles; or should or should not be valued or devalued, and in whose eyes; or should or should not be afforded the good things of life), one must derive answers to such questions from one's value system; that is, from one's *de facto* religion (Wolfensberger, 1995).

In this treatise, my primary focus is on *societal* (rather than only personal) devaluation, on such devaluation in *our* society, and how such devaluation could be combated via SRV. In order to evolve this exposition, I first sketch a few important realities and facts: (a) who the classes of people are who are widely devalued in our society, (b) some of the bad things that are likely to happen to them, and (c) some facts about social roles and social imagery.

The Classes of People Who are Widely Devalued in Western Society Today

In our society—and indeed in much of Western societies generally—the following classes of people are apt to be devalued by a significant proportion of society.

1. People who are impaired in some way, as perhaps in their senses, bodies, or minds.
2. People who are seriously disordered or unorthodox in their conduct or behavior, including (a) those who are either excessively active (the hyperactive) or not active enough (the lethargic, the lazy); (b) those considered disordered or unorthodox in their sexual identity and/or conduct; and (c) those who are self-destructive, including those enslaved to alcohol and other drugs.
3. People whose visible bodily characteristics are viewed very negatively, such as those who are very disfigured, obese, short, tall, etc.
4. People who rebel against the social order, which might include political dissidents, those who refuse to work, and those who violate the law.
5. The poor, who have been very devalued in our society since at least ca. 1500.
6. People who have very few skills or whose skills are not wanted or useful to society, such as the illiterate and unemployed.
7. People who are unassimilated into the culture for any number of (other) reasons. Historically, this has included (a) members of racial and ethnic minority groups; (b) members of religious minorities, particularly if these also take a stance against the political and/or value system of the culture; (c) those who do not know or use the prevailing tongue; (d) illegal immigrants and/or immigrants of a devalued ethnic group; and (e) migrant laborers. Lately, this has also increasingly included (a) people at the extremes of the age spectrum—the elderly, the unborn, and the newborn; and (b) teenagers. Of course, some devalued classes are much more devalued than others and, hence, at greater risk than others, including people who fall into several of these categories.

Typical Negative Life Experiences of Devalued People

When people are devalued by others, there is then a high probability that the devaluers will act in ways that impact negatively on the lives of the devalued ones. In fact, this is nearly certain to happen to members of a class that is devalued by the majority of its society. I have called these negative experiences the "wounds" of devalued people and briefly review them here:

1. Some people become devalued because they are impaired in body, including in brain or sense organs, whereas others become thusly impaired as a result of being devalued. For instance, people may become bodily impaired as a result of poverty, poor nutrition, unsafe living conditions, poor health care, or being assaulted—all things that are very likely to happen to them as a result of having been devalued.
2. Similarly, many people become devalued because they are impaired in functioning, and many others become functionally impaired (e.g., illiterate) as a result of being devalued.
3. Once devalued for the above or other reasons, people are at extreme risk of getting relegated to low social status in society and of being looked down upon, perhaps as second-class citizens—or even worse.
4. As a result of, or in connection with, being relegated to low social status, devalued people also get systematically rejected, not only by society but often also by their community, neighbors, family, and by many human service workers. Rejection means that other people do not want a certain party around. People strike many wounds via their behavioral expressions of their internal feelings of rejection, however unconscious these processes may be.
5. One consequence of Wounds 3 and 4 is that devalued people get cast into roles that are devalued in society, even as their access to valued roles is severely diminished. Typically, there is some kind of link between why a party is devalued and the specific devalued roles that get imposed on it, or the valued roles that get withheld from it. In other words, the devalued party is commonly given a role identity that confirms and justifies society's ascription of low value or worth to that party.

   Some of the major common negative social roles into which members of societally devalued groups have historically been apt to be cast are the following: (a) the nonhuman, and specifically the pre-human (e.g., the unborn or newly born), the no-longer-human (e.g., the comatose), the subhuman (variously characterized as animal, vegetable, or object), and the human as "other" (e.g., like a creature from another world); (b) the menace role, or object of dread; (c) as waste material, garbage, offal, excrement; (d) as a trivium, perhaps as an object of ridicule; (e) the object of pity; (f) the object (perhaps even dutifully borne burden) of charity; (g) the child role, most typically either as the "eternal child" or as being in one's "second childhood"; (h) the ambiguous borderline role of the (holy) innocent; (i) the sick role; and (j) death-related roles, such as dying, as-good-as-dead, should be dead, or already-dead. Negative roles that have more recently been ascendant, and into which devalued people are now often cast, include those of victim and dependent (on the service system) client.
6. Another wounding expression of rejection is that devalued people get systematically and relentlessly juxtaposed to images that are drawn from the negative polarity of value messages (Table 1). Here are some common examples. Services to devalued people are apt to get placed in locations where valued people do not want to be; devalued people get juxtaposed to, or even congregated with, other people whom society also does not want; image-degrading language is used with or about them, and

Table 1
Examples of Culturally Prevalent Quality Polarities

	Negative pole	Positive pole
Virtue	Sin/diabolical/evil	Virtue/angelical/divinity
	Irresponsibility	Responsibility
	Criminality/corruption	Lawfulness/morality
	Pity/charity	Respect/entitlement
Attractiveness	Ugliness/disorder	Beauty/order
	Darkness/blackness/shadow	Light/white/bright
Life-related	Illness/death	Health/vitality/life
	Incapacity/impairment/weakness	Strength/power
	Cold	Warm
	Old	New/youth
	Decay/decline	Growth
	Subhumanity	Humanity
	Incompleteness/brokenness	Wholeness/completeness
Place	Bottom/down/low/below	Top/up/high/above
	Back	Front/forward
	Left	Right
	Last/end	First/beginning
	Out	In

image-degrading names are given to their services; elements of their personal appearance that attract negative attention are not addressed, or the negative elements of their appearance may even get enlarged; and services to them are funded by appeals that are image-tainting. Such things can constitute or convey negative messages (e.g., that these people are worthless, subhuman, menaces, dangerous, or despicable) and, furthermore, such imaging perpetuates the operative social devaluation, and virtually invites other parties to do bad things to the devalued party. It is as if a flag were being raised that signals, "Here are people of low value to whom you may, or even should, do bad things."

7. Devalued people—especially once they have been rejected and negatively imaged—are at extreme risk of being scapegoated for other people's problems, and even societal ones.
8. People tend to put distance between themselves and those they devalue and reject. They may do this by removing themselves or by moving the devalued people away. Most typically, they segregate (and usually also congregate) devalued people or otherwise get rid of them.
9. Devalued people experience loss of control over their lives, as other people gain power over them and make decisions for them.
10. Many devalued people experience a very wounding discontinuity with places and physical objects, including possessions. In part, this is the result of having little control over one's life and of getting moved about a lot. There can be scores of these kinds of discontinuities in a devalued person's lifetime, and many can be quite traumatic.
11. Commonly, the devalued person also suffers a great many social and relationship discontinuities, meaning that people come and go in that person's life. Many of these people (especially paid ones) make either explicit or implicit promises that they will be friends and helpers, and yet all of them may end up leaving, perhaps after only a brief presence. When such an explicit or implicit promise has been made and then gets broken, the wound of social discontinuity is compounded by the wound of betrayal.
12. Quite naturally, when other people withdraw from contact with a devalued person, this also means that natural relationships—such as those with family, friends, and community members—either never develop in the first place, or get withdrawn or severed. When natural relationships are no longer freely and voluntarily extended to devalued people, other people then have to be recruited to do what may be needed, and these other people almost always have to be paid because that is the only reason they would get or stay involved. When such payment ceases, so does their presence. So the lives of devalued persons often begin to be filled with artificial and "boughten" relationships that are really substitutes (*ersatz* relationships) for the "real thing." Some devalued people do not have even one single enduring unpaid relationship, especially not of any quality, and not with persons who are not also devalued themselves. In recent years, animals have even been recruited for *Ersatz* relationships.
13. Devalued people also tend to get deindividualized and subjected to mass management and regimentation.
14. Devalued people commonly are, or become, poor.
15. Devalued people also suffer impoverishment of experience. Their world is often very narrow. Many experiences that valued people take for granted may be very foreign to them.
16. One particular experience from which devalued people may get cut off is knowledge of, and participation in, value systems and spiritual life—even of their own religion.
17. One of the major results of all this is "life-wasting": Devalued people's time and lives are junked. Not just days and weeks, but months, years, or a lifetime can go by while they are waiting for opportunities, challenges, experiences, emotional comforts, etc. When they receive a service, it is often the wrong kind, or at any rate, of less intensity or quality than they could benefit from, or than valued people would get. Many devalued people get wasted in or by the very service programs that are supposed to help them.
18. Devalued people are very much at risk of being brutalized and violated, even to the point of being made dead, the latter being the ultimate removal. They may get assaulted on the streets, in their families, or by their service workers, and some people think they are justified in ending the lives of such persons, perhaps even as a supposed act of mercy.

The bad things that characteristically happen to devalued people are not only hurtful but can become outright life-defining. Examples are living in poverty, being perceived for much of one's life as a social menace or as subhuman, or leading a segregated life.

People are particularly likely to get wounded if they embody not only one but several qualities that their society devalues (i.e., that are the opposite of what society values). For instance, people who are of low intelligence, *and* unattractive, *and* unpleasant, *and* elderly, *and* sickly are virtually certain to be more devalued, and much more wounded, than people who are only one of these things, and they are vastly more likely to be made dead.

The wounds are not only experienced on the individual level, but entire classes of devalued people may be subjected to characteristic patterns of wounding. Gypsies, people with AIDS, debilitated elderly people, etc., are each apt to experience a pattern of wounding that is almost cut to a template for their class.

If people have been wounded deeply enough—especially early in life—then this can result in a very disturbed relationship to the world. They may feel like aliens in a world where they do not fit in. They may think of themselves as worthless and unlovable, that this is their own fault, and that they deserve misfortune. They may succumb to despair and turn self-destructive. Many of the wounds (e.g., instability of place and relationships) make people feel insecure. Such persons may develop a self-fulfilling expectancy to fail. They may grieve over the fact that they are not what others hoped they would be, and that for those who do love them, they are a source of anguish. They may go on a quest to reestablish relationships with people who abandoned them (e.g., parents), and perhaps develop fantasies that certain others love and want them. They may become distrustful, and put new relationships to tests that can be so hard that no one will pass them. Some such persons become embittered, perhaps full of resentment and hatred toward the privileged world, and they may withdraw from it and even from reality itself. Some such people turn their rage on the world, possibly with violence. And laboring under the burden of one's wounds can be so mind-absorbing and mind-abrading that one may function very inefficiently, act stupidly—or even become stupid.

A thoughtful and sensitive analysis of the phenomenology of the wounds of a person is usually much more revealing than is the administration of professional and technical assessment devices, and their interpretations.

Social Role Valorization as a Role Theory-Based Response to Social Devaluation and to the Wounds It Inflicts

There are many ways in which people try to address the ills of the world, including the woundings and woundedness of people. These modes of address can range from the religious to the scientific and from being very powerful to being counterproductive. Not even the valid and powerful ones will ever solve all problems. Of many possible such responses, SRV is merely one, namely one that is rooted in the empiricism that is associated with role theory, and one needs to be familiar with a certain amount of this theory to appreciate its capacity to address devaluation.

A Few Points of Role Theory

A social role may be viewed as a combination of behaviors, functions, relationships, privileges, duties, and responsibilities that is socially defined, is widely understood and recognized within a society (or at least within one of its subsystems), and is characteristic or expected of a person who occupies a particular position within a social system. In role theory, a large part is played by expectancies, both those held in the minds of perceivers who view someone as occupying a certain role as well as those expectancies held in the mind of the perceived who fills a role, or is being role-cast. When a person is perceived—at least in a general way—to be living up to the expectancies associated with a particular role, then that person is considered to be carrying out, or filling, that role and is apt to be confirmed or legitimized in it. Conversely, people who do not meet the expectancies held for a role are not apt to be confirmed or legitimized in it.

There are multiple ways to classify roles, but for SRV purposes, I believe that classification into eight domains is very useful (see left column of Table 2). Furthermore, roles can be placed along a continuum from deeply devalued to highly valued ones. Table 2 lists some examples of both positive and negative roles for each of the eight domains, with valued roles that have been held by at least some mentally retarded persons shown in italics. Most people occupy many roles, and from several or all role domains, simultaneously: several relational roles, one or more occupational roles, several civic ones, several economy-related ones, several avocational ones, etc.

On a population level (i.e., probabilistically), one will find much agreement about the values that are attributed to all sorts of social roles. For instance, the roles of college professor, inventor, elected public office holder, and star athlete are—at least across the board—vastly more likely to be valued than the roles of garbage collector, beggar, and chronic invalid. Of course, some valued roles are much more valued than are other valued roles, and some devalued roles are much more devalued than are other devalued roles. For instance, without devaluing the role of an assembly line worker, most people would still value the role of a factory manager higher and would devalue the role of career burglar more than that of a habitual liar.

Although, ultimately, all roles can be said to be attributed or ascribed, some are nonetheless "competency-contingent" (i.e., they require some competent performance and, hence, certain competencies by those who would fill them). ("Competency" here should be understood in the widest sense, subsuming not only knowledge and skills, but also adaptive habits, social facility, health, etc.) The less competency a role requires, the more does attribution come to the fore. For instance, almost all work roles require some competencies, whereas many relationship roles (e.g., "my son/daughter/brother/sister") require few or none. Some roles (e.g., "customer" or "citizen") are very elastic as to the amount of competency they require.

Furthermore, social roles can be—so to speak—big or small. Big ones fill more of a person's life and/or are more defining of the person to others and usually also to the role incumbent him/herself. Roles such as spouse and parent, learning (e.g., student) or work roles, "wanted criminal," "prisoner," or "star athlete," tend to fall into this category. Small roles (e.g., bank customer, dental patient, and voter) fill less of a person's life, and/or may only be carried out in very few places and/or at few times, and are less life-defining.

In turn, this implies that the value that people attach to the big roles of a party will have more of an impact on that party's life than the value they attach to the party's small roles. However, being the incumbent of a large number of small valued or devalued roles can still add up to considerable significance. Also, roles that are small ones for most people can inflate into life-defining ones for certain other people.

The literature on social roles is vast. Readers will gain access to many relevant overviews, documentations, and other references from Lemay (1999).

Table 2
Major Role Domains With Positive and Negative Examples

Role domain	Positive role examples[a]	Negative role examples
Relationships	*Wife, husband, parent, grandparent, brother, sister, son, daughter, aunt, uncle, fiancé, friend, confidante*	Old maid, orphan, black sheep of the family
Residence, domicile	*Home- or land-owner,* building superintendent, *good neighbor, tenant*	Homeless street person, hobo, vagabond, bad neighbor
Economic productivity, occupation	*Worker, laborer, wage-earner, apprentice, expert, craftsman, breadwinner, union member,* employer, boss, *business owner*	Idler, loafer, ne'er-do-well, union-buster, scab, informer, welfare recipient, "sponge"
Education	*Teacher,* professor, scholar, *student, peer-tutor, peer model*	Dunce, special class student, drop-out
Leisure, sports, recreation	*Athlete, competitor, champion,* coach, *fan, booster, cheerleader, hobbyist, club member*	Oaf, klutz, loser, sore loser, bad sport
Community/ civic identity & participation	Public official, *citizen, voter,* taxpayer, *community activist, advocate,* board *member, juror, patriot, service volunteer, committee member*	Foreigner, subversive, outsider, dissident, traitor, prisoner
Religious & ethical beliefs & practices	Pastor, rabbi, acolyte, *cantor, chorister,* deacon, *sexton, candle-bearer, bar mitzvah graduate, parishioner, philosopher, thinker*	Sinner, lost soul, apostate, faddist
Culture	*Arts patron, artist, music-lover, book-lover author, actor, dancer, (amateur) musician,* literatus	Philistine, boor, illiterate

[a]Italicized roles are valued roles that have been held by at least some mentally retarded persons.

Why Social Roles Are So Important

Among the reasons social roles are so important, four stand out.

1. Roles give a person a "place" vis-à-vis others and in society, and it is largely via their roles that people define and situate themselves in the world. For instance, almost all of one's relational behavior is profoundly informed and shaped by the roles one holds. As well, it is largely via roles that people define and situate others in the world, in that roles give people at least a preliminary mental "handle" as to who a person is and how they should relate to that person. This is why people typically seek role-related information about a person they encounter: age, sex, marital and family status, education, occupation, nature of employment, etc. In America, the first thing people are apt to ask someone they have just met is "what do you do?" meaning "what kind of work are you in?" All this explains why it is outright difficult to talk about specific individuals without invoking social roles, as one will discover if one tries to do so.

   One phenomenon that underlines the importance of social roles is what Lemay (1999) has called "role avidity"—i.e., "role hunger," meaning that people very much want to see themselves in socially recognizable roles. Role avidity explains many (usually maladaptive) phenomena, such as people ludicrously expanding a minor role into a life-consuming one, preferring even devalued roles to no roles at all, or preferring a big devalued role to several small valued ones. It follows that role avidity is apt to be highest in those people (e.g., many retarded ones) who want more social relations, but do not inhabit roles that lend themselves well to establishing or maintaining such relations.

2. In their totality, the roles that people fill affect just about every aspect of their lives (e.g., what relationships the person will have with others, or will even be permitted to enter into); who the person will (be permitted to) associate with; where and with whom the person will live; what sorts of things the person will do during the day; what the person's schedules and routines will be; what sort of economic status and income the person will have; the degree of respect the person will

be accorded by others; the kind of autonomy the person will enjoy; whether and how much the person will participate in community affairs; even such things as health, health care, diet, and what clothes one wears—and more—will be strongly influenced, or even determined, by one's roles. However, there is also a two-way relationship between a person's real or attributed characteristics and a person's role: One may end up in a role because of one's characteristics, but whatever roles one is placed into for whatever reason also tend to strongly shape one's characteristics, one's behavior, and even one's identity.

3. The more a person holds "big" roles that are highly valued, the more are other people likely to put up with the person's other negative roles, characteristics, or behaviors, or even reinterpret these as being not so bad. In other words, holding big positive roles is a strong defense against being devalued on account of other reasons.

4. Altogether, it is a major thesis of SRV that, at least on a probabilistic and long-term basis, society will extend whatever good things it has to offer to people in valued roles and may even push these on such people, but will do bad things (or little or nothing that is positive) to those in devalued roles.

These four points imply that people who have some kind of impairment, but who occupy valued roles—and especially "big," many, and highly valued ones—are much more likely to (a) be spared some of the bad things that are likely to befall impaired people in negative roles, and (b) be beneficiaries of the good things that are commonly afforded to people in valued roles.

Many Valued Roles Are Potentially Available to Impaired or Devalued People

Fortunately, there are many positive roles that are potentially available even to already devalued people. For all the valued roles shown in italics in Table 2, there are at least some mentally retarded persons who have held them, and some of these roles—such as some relational ones (e.g., friend)—can be held by *all* retarded people. Also, these are merely some examples. Particularly in some domains, such as that of economic productivity, the number of potential positive and more specific roles is virtually infinite.

The Relationship Between Social Roles and Social Images

The previously mentioned construct of "imagery" plays a prominent part in SRV. Images are mental pictures, so to speak, that are commonly evoked in response to, or in connection with, or as the result of a juxtaposition to something else: a stimulus, an event, a perception (of people, places, objects, etc.), a memory or an idea, a social stereotype, etc. For instance, ideas of romantic love are apt to be evoked by images of hearts, smooching turtle doves, and bells and wedding rings—but also vice versa, such ideas are apt to evoke the corresponding images.

If in the mind of an observer, two or more entities somehow have gotten associated with each other, and one of these entities has certain images attached to it, then in the observer's mind, these images will tend to become transferred, and attached, to the other entities as well. Such image transfer can occur from entity A to entity B, from B to A, and from each to the other simultaneously. Many factors affect what associations get thusly transferred in people's minds, into which direction they are transferred, and whether the implied message is positive or negative.

Important to our context is that images that are conveyed about people can communicate both role messages and value messages; and, in turn, roles can convey images and value messages. In fact, it is hard to think of a social role without all sorts of images coming to mind that pertain to that role. For instance, the role of "soldier" evokes images of uniforms, discipline, rank, military bearing, gestures (e.g., salute), weaponry, and marching. The role of "criminal" is apt to evoke images of a male, perhaps of uncouth appearance and with an oversized jaw, wearing a face mask, and carrying a weapon. In turn, if one perceives a police badge, one is apt to think of the role of a police officer. If one is shown a jail cell, one is apt to think of the role of "prisoner."

When positive images are attached to a party, that party is more likely to be first viewed positively, and then to be accorded or afforded positive roles. Negative images associated with a party are more likely to result in that party being first devalued and then cast into negative roles. And all this is apt to get done with little or no consciousness, because a major portion of human perceptual, learning, and even

cognitive processes—not to mention social interactions—is unconscious. Therefore, much in the domain of imagery, expectancy, and roles is also unconscious, and particularly so are one's social devaluations and one's attachment of negative images to people whom one devalues. The reason is that at least in Western cultures, such actions are judged to be unworthy, so one feels guilty about them and, therefore, represses what they really mean, or that one is even complicit in such devaluations and corresponding actions.

However, how a particular message about a party is interpreted by perceivers will often depend on who the message is about. People are known to tend to interpret messages as confirming their pre-existing positive or negative stereotypes of a party. This implies that although negative value could get transferred to anyone who engages in a negatively imaged activity, behavior, or juxtaposition, it can wreak vastly more damage if it plays into already pre-existing negative stereotypes about them. Also, it takes vastly more evidence to overcome a negative stereotype than to confirm it. For instance, people who have cancer or AIDS are much more likely to be death-imaged if they are served in a building that was once a morgue and is next to a cemetery than would be the pupils of a school for gifted youngsters located in such a building.

In respect to low intelligence specifically, the negative images it has been apt to evoke have been those of childishness, gaping, staring, drooling (as in "driveling fool"), slowness and clumsiness of movement, distractibility, slow and indistinct speech, inappropriate affect, being inappropriately dressed, etc. Because such images are found in innumerable cultures around the world and across historical eras, one can call them archetypal. Furthermore, many roles associated in people's minds with low intelligence are negatively valued, such as the eternal child; the village idiot; the performer of very lowly and unskilled work tasks, perhaps with a strong body but clumsy movements; the sex offender against children; and the fire-setter. Historically, there have also been some positive images about, and roles for, retarded people: child-like innocence, joy in simple things, gentle and loving consoler, forthrightness, ice-breaker at social gatherings, conscientious worker, devoted follower of a religious faith, other people's moral conscience, etc. Some of these images and roles have been sketched in Wolfensberger (1988a) and debated by Berkson (1988) and Wolfensberger (1988b).

The avenues for conveying either value-laden image messages, role messages, or expectancies about people can be classified into the six categories sketched below.

Physical contexts and environments. Where people are and get put can carry very strong images as well as role and value messages. For instance, if one encounters a place that is called a hospital, one expects to find sick people and medical personnel in it. This can be a problem if the "patients" there are really not sick at all but have merely been interpreted that way and cast into the sick patient role. (This is, in fact, often done to mentally impaired people.) If one goes to a department store, one would generally assume that all the people there are either customers or sales personnel. If an environment is set up like a cage, with surfaces that can be easily hosed down, and with a drain in the floor, one might get the message that animals live there—and if people get put into such an environment, it is usually because they had been cast into an animal role, and observers are then likely to view them that way. If an environment is full of furnishings, decor, and objects associated with childhood, one will expect to find it used by children, but if instead one finds that it is used by adults, then observers are apt to cast them into the child role. (Again, these last two scenarios have been common in the history of mental retardation.) A dirty environment reflects negatively on the people in it, above and beyond whatever role messages it may convey.

All this means that impaired people are apt to be image- and role-enhanced if they live in the same kinds of places, and are schooled in the same settings, as valued persons; if they worship in ordinary churches where ordinary people worship; if their settings are comfortable and beautiful, clean and well-kept, and blend harmoniously with their neighborhoods; and if their environments convey accurate and positive messages about their age and optimistic messages about their capacities for growth and development.

Social contexts and associations. Social associations can strongly convey role messages. There are innumerable folk sayings about how one is defined by the company one keeps. More specifically, when persons with the same impairment are juxtaposed to each other, the idea that all such people "belong together" is conveyed to, or reinforced in, observers. Relatedly, the

idea can easily take hold in an observer's mind that the less impaired persons in such a juxtaposition are actually as impaired as the more severely impaired ones.

Further, when people who have one kind of impairment, other devalued condition, or "wound," are juxtaposed to people who have another kind, observers also commonly get the idea that both parties are somehow the same. Thus, each party is viewed as having not only its own impairments or wounds, but also those of the other party or parties with whom it is juxtaposed. For instance, if mentally retarded people are all mixed in with cerebral palsied people, the retarded people are apt to be assumed to be physically impaired, and the cerebral palsied people are apt to be assumed to be retarded, even if neither is the case. Because mentally retarded people are already culturally stereotyped as eternal children, then grouping retarded adults with nonretarded children, or retarded youths with much younger nonretarded youths, will also reinforce the child role stereotype of the retarded party. If a person who had once been convicted of pedophilia is not permitted to work in a kindergarten for privileged children, but is allowed to work with a group of impaired or poor children, this conveys a negative message about the value of the latter, such as that they are guinea pigs, already ruined, unimportant, or expendable.

In contrast, mentally handicapped people are apt to acquire—or retain—positive imagery and role expectancies by being associated with people who are perceived as competent, vigorous, moral, distinguished, etc., and who occupy positive roles. However, in order for such positive image transfer to take place, it is generally important that only a small number of devalued persons be associated with, or juxtaposed to, a much larger number of valued ones, because it is the majority—and even predominant—identity of any social grouping that is apt to define its individual members in the eyes of observers.

Behaviors and activities. Behaviors, activities, and how these are carried out and timed can also convey positive or negative images and messages about people and their roles. For instance, vigorous activities carried out over normal or even long periods of the day, week, or year convey images and messages of strength, persistence, commitment, competency, etc. Negative messages are apt to be conveyed if people engage in activities or schedules that are viewed as negatively atypical, either for people of their age (and, thus, being age-inappropriate) or for anyone in their society (and, thus, being culture-inappropriate).

To come back to the issue of pre-existing stereotypes: If valued people took up chair-caning or broom-making as a hobby, it might be judged positively; but if blind people did it, it would reinforce an ancient stereotype of the blind role because for centuries, a large proportion of blind people had been first sluiced, and then dead-ended, into these occupations.

Certain activities, settings, and social juxtapositions tend to go with each other, and these typical combinations can have characteristic positive or negative valence. For instance, if one attends a college, one is apt to carry out one's activities in juxtaposition to faculty members, custodial staff, librarians, and other students, with the overall valuation of the combination usually being a positive one. In contrast, a negative valuation is apt to be incurred from the larger culture if six college students go joyriding in a red-light district at 2 a.m.

Language used with or about people, or about anything associated with them. Language can powerfully communicate about people in a number of ways. About people of low intelligence specifically, many languages have hundreds of words or phrases, almost all of which evoke negative images and role ideas: eternal child, dumb ox, blockhead, village idiot, vegetable, low-grade, and so on.

When people are addressed with value-degrading language, it may hurt their feelings; but if the same language is used to talk (or write) *about* them, then negative ideas and feelings about them get planted or reinforced in the minds of *others*, who are highly apt to convert these sooner or later into behavior that is vastly more damaging than hurt feelings.

But language can also be used to convey positive messages about people, as by addressing them, or speaking about them, in ways that dignify them or imply positive roles: Mr. or Mrs., our guest, employees, chairperson, athlete, a good worker, my brother, etc.

In addition to terminology, there is tone of voice and gestures. So often, impaired adults and aged people are spoken to in high-pitched melodic voices—the same tone most people use with children and pet animals. This is "the child role voice," telling us that anyone thusly addressed is perceived in the child role, perhaps because they are presumed to have never grown up or to be in their "second childhood."

Also relevant are the names, acronyms, and logos adopted by organizations and agencies concerned with (devalued) people. A logo that looks like a child's stick figure suggests that the adults with which the organization is concerned are child-like; acronyms such as RIP or TOMB suggest death, while VITA suggest life, etc.

Personal appearance. A person's appearance (e.g., dress, hygiene, grooming, posture, mannerisms, and accessories such as jewelry) can send out strong positive or negative messages. So commonly, the appearance of mentally impaired people does not project a positive image. They may wear clothing that is ill-fitting, out-of-fashion, worn out, torn, dirty, or immature for their age; they may carry themselves awkwardly, having never been taught graceful movement and good posture; they may have poor hygiene habits and, hence, bad body odor; and no effort may be made to help them look attractive or even elegant.

Also, much as certain activities and social juxtapositions tend to go together—for better as well as for worse—so do personal appearance and the physical context. Thus, a person's appearance may be very positive—but only if it accords with a certain setting (e.g., leisure clothes do not go well with business settings, business clothes look weird on a beach, etc.).

Many people would be prepared to perceive mentally impaired people more positively if their appearance features were fashionable, dignified, or even distinguished, and concordant with the setting. For instance, if impaired people were trim and in good physical condition, showed good hairstyling and grooming, wore high-quality clothes that fit well and were appropriate to the occasion and setting, wore tasteful jewelry, etc., then—like it or not—they would be more apt to be seen in valued roles that correspond to the respective physical context: student, employee, athlete, shopper, theater-goer, etc.

Miscellaneous role and image communicators. There are several other channels that can convey role, image, and value messages. One is the funding that supports a person or service. For instance, the image of an impaired person is not enhanced if: the person's pension or health coverage comes from a funding category for the "totally and permanently disabled"; the flowers in a hospice for the dying are regularly donated from funerals; or separate government offices dealing with impaired people, and with drug and alcohol abuse, are combined into a single Department of Disabilities and Drug and Alcohol Abuse.

Very important in the application of SRV is that people will accord roles to others on the basis of what information they *believe* they possess about them and consider to be relevant: what such persons look like, where they live and with whom, what they do, what their schedules and routines are, what their income or possessions are, how healthy they are, what and how they eat, what they wear, etc.—in other words, on the basis of whatever messages have been conveyed via the various role and image communicators. For instance, if an observer sees a person who lives in a segregated housing project for the poor, who spends most of the time idly "hanging out" on the street corner, who seems to arise late in the day and stay up all night, and who wears expensive clothes and flashy jewelry and drives a luxury car, then the observer is apt to conclude that the person is a criminal drug-dealer and will act accordingly—even though the person may turn out to be an undercover police officer. Similarly, if people see mentally handicapped adults engaged in childish activities, in schools or playgrounds, dressed in childish attire, spoken to as if they were children, and being supervised by teenagers, then the public can hardly help but conclude that these adults really are only big children—and no amount of rhetoric and protests by well-intentioned advocates will change this perception. Rather, the information conveyed to observers via the image and role messages must change. So the messages from all the channels just reviewed summate in observers' minds into some global conclusion about the social value of the observed party and the role(s) it fills.

The Relationship Between Social Images and Competency Within a Social Role Valorization Framework

Although both competencies and images will affect people's roles, we also need to appreciate that a complicated feedback loop exists (Figure 1) among competencies, images, expectancies, roles, and opportunities, and that this feedback loop can work to the benefit or the disadvantage of a party—perhaps decisively so, because the feedback effects are very powerful.

On the one hand, if some party possesses a positive image, this almost always motivates others to either accord that party positive roles,

or at least to afford that party greater opportunities to move into more valued roles and/or to acquire competencies needed to fill valued roles. For instance, people who are imaged as "smart" and "capable" tend to be offered leadership roles and/or opportunities to develop their capacities. In turn, the acquisition and possession of most competencies tends to enhance a party's image in the eyes of others. For instance, esteem for a person almost always rises as one learns all the things that this person can do.

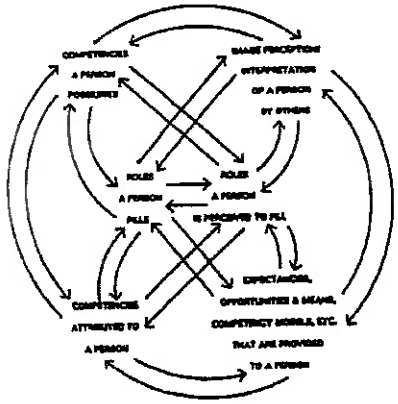

Figure 1. Feedback loop among image, competency, roles, and their perception.

On the other hand, if a party has a negative image, then others are not likely to afford to that party the opportunity to gain competencies, or even to exercise the competencies already possessed. For instance, if an individual is imaged as an eternal child who will never grow up, other people are less likely to give that person the chance to show that he or she can in fact grow and mature, or has grown and matured. And if a party lacks competencies that are seen as important (e.g., literacy), then this contributes to a bad image in the eyes of others. Even if a party is attributed with competencies that it does not really possess, the party may still benefit from this feedback loop, in that its image is apt to be enhanced—in the same way that a party assumed not to possess certain competencies that it does in fact possess can suffer image harm and denial of opportunities.

A Practical Step-Wise Regimen for Applying Social Role-Valorizing Measures to a Specific Party

When one is ready to apply SRV to a specific party (which could be either an individual or collectivity), then one can vastly increase one's chances for success by adhering to a six-step regimen sketched below.

Step 1. Becoming Familiar With a Party's Wounds

If one is dealing with a party that has been wounded because of its devalued status, then it is absolutely necessary to deeply familiarize oneself with those wounds.

Step 2. Knowing a Party's Risk Factors

In addition, one needs to know in what respects a party is vulnerable (i.e., what the areas of high risk are for that party). For instance, elderly persons are at higher risk of developing health problems, elderly women specifically are at risk of breaking bones, and gypsies are at risk of being accused of theft. Mentally retarded persons are at risk of being taken advantage of by people who are smarter and unscrupulous, and of being expected to fail at tasks that require learning or competency; they tend to be less emotionally mature than other people their age; and most of them are at higher risk of committing a *faux pas* in how they groom and dress themselves. Many people are at risk of having shameful facts about them revealed that would damage their current standing, such as previous devalued life styles, institutionalisations, conflicts with the law, or incarcerations. Furthermore, certain devalued classes are apt to have certain devalued roles imposed on them, as when mentally distraught people are cast into the sick role; poor people into the burden of charity role; blind people into the pity role; aged people into death-related roles; and mentally retarded people into the child, animal, discard, or object of ridicule role.

Among the mentally retarded, two risk points have recently become more common. One is with retarded children who are doing well in an integrated schooling situation but who may drop back into much less favorable circumstances when they "age out" of school. Another is with many mentally retarded adults who enjoyed 10 or 20 years of reasonably good living and working situations, but whose circumstances can rapidly deteriorate already in their mid-years. Altogether, failure to take risk factors into account often has devastating consequences.

Step 3. Inventorizing a Party's Current Roles

One makes an inventory of both the positive, the negative, and the in-between, ambivalent, or mixed roles that the party currently holds.

Step 4. Explicating a Party's Current Societal Standing

In part with the help of the above inventories, one forms an overall idea of the party's current social standing and value in the eyes of society. Is the party highly valued, of average standing, marginally on the positive or negative side of neutral, deeply devalued, of equivocal value standing, or what? The previously mentioned risk analysis will be very informative here, because it is conceivable that a party—even if currently valued—may have a higher-than-average risk of a particular kind and may need more than ordinary safeguards in that risk area against role-degradation and loss of social value.

Step 5. Reviewing Certain Practical Realities About Image Versus Competency Measures

Four overall considerations about roles, images, and competency will be helpful as one applies SRV.

(a) One needs to form a judgment as to whether—in the case of a particular party—the enhancement of competency, or of imagery, would be more likely to be effective. For instance, a competent person released from prison can be expected to benefit most from image enhancement, while for a person who recently lost competencies due to an accident, restoration of the lost competencies may have primacy. The image problems of mentally retarded persons are usually secondary to their competency deficits, which may have certain action implications.

(b) At the same time, one also needs to form a judgment about whether the most desirable measure is also reasonably feasible. For instance, with severely mentally impaired persons, competency enhancement may be the theoretically most effective measure, but image enhancement may be the only thing that may be practical to accomplish. Also, in many people's cases, image enhancement is the first and easiest thing one can do, whereas competency enhancement may be a long and drawn-out process. In contrast, children tend to absorb age-appropriate competencies like a sponge, so competency enhancement may be highly feasible with them.

In regard to both (a) and (b), the fact is that the less accessible any competency-related roles are, the more important become attributed or ascribed roles, and often specifically relationship-based ones.

(c) The more that a party who is already in devalued roles, or who is at significant risk of role-degradation, is seen by others (i) in places frequented by valued people in society, *and* (ii) in actual association with valued people, *and* (iii) in activities that are valued, the more are role-valorization benefits apt to accrue to that devalued party, often first in the image domain and sometimes also, and, derivatively, in the competency domain. This is especially apt to be true if the valued people who associate with the persons at issue do so without being coerced, or feeling resentful about it. In contrast, if even one of these three positive elements is missing, then people's image certainly, and sometimes their competency as well, are apt to suffer. For instance, if a devalued person goes to a fancy theater for a performance of a Shakespeare play, but all the other members of the audience are also members of devalued (perhaps impaired) classes, then this person's attendance is not apt to be seen by a perceiver, or the public, as being as valued and valuing as if the audience had been a typical one for such an event.

(d) It is very important that in efforts to enhance the image of a devalued person, one does not become deceptive. If one projects onto a person images of competency or positive roles that the person does not possess, this could have devastating consequences: (i) observers may expect something that the person cannot do, which in turn could endanger the person, could confirm such a person's failure expectancies, and/or could confirm observers' negative stereotypes about such persons, and (ii) the parties who conveyed the false messages may lose all credibility.

Step 6. Identifying the Currently Held, or Desired, Roles That One Wants to Valorize or Change to a Party's Advantage (i.e., the Role Goals)

Leaning again on the earlier inventories, it

is now time to begin to select one's role goals, and there are up to six types to select from. However, at least the first four of the five steps reviewed earlier must be taken *before* one is in a good position to decide which of these goals to pursue. The fifth of the above steps (with its four considerations) can be incorporated into the design of any of the role goals that follow:

Valorizing the positive roles a party already holds. If the previously established inventory has identified any positive roles a party already holds, then one relevant measure is to explore what can be done to further valorize one or more of these roles. This is particularly important if the party at issue does not hold many valued roles or also holds some devalued ones. There are two distinct subgoals here.

(a) The first one is to enhance—perhaps by enlargement—one or all of the valued roles already held. An example of an image measure would be to upgrade the title of a person's valued role. An example of a competency measure would be to help a person to acquire new skills so that he or she can perform additional valued functions within one or more valued roles already held. For instance, an impaired worker might be taught an additional skill for an enlarged work role. If, for whatever reason, a person begins to lose mental faculties, hence competencies, and their competency-related roles, it then becomes particularly important to enlarge those valued roles held by the person that tend to depend less, or not at all, on mental acuity, such as the person's relationship roles.

(b) The second subgoal is to defend the valued roles already held against losses, diminishment, or degradations. This is particularly important when a party is at distinct risk of losing one or more of its valued roles, for example when an individual's job is in jeopardy or a person acquires a chronic bodily affliction or becomes elderly. There are often things that can be done to prevent, delay, or reduce such role losses. It is important to practice high consciousness of these risks, how they commonly lead to wounds, and to counter them as early and vigorously as possible.

For instance, along mostly image lines, a family could make sure that their impaired son participates as much as possible in all family occasions and that his personal spaces are full of signs of family membership and participation (e.g., photos), so as to reinforce his familial and relational roles, for example, as beloved son or brother. A person who has brothers and sisters who live far away might (be helped to) maintain contact with them, perhaps by telephone, letters, remembrance cards or gifts on birthdays, exchanging photographs, arranging for a reunion, etc. This might defend such valued relationship roles against losses. One has to be clear that the issue here is not only one of having beneficial affective relationships, but also of having roles perceived by others to be valued.

In regard to competency, an impaired young adult who is about to graduate from school and is unable to get a job might be helped to continue the student role in a valued adult manner by, for example, enrolling in evening courses where other adults are enrolled. There have been adults who could not get or hold jobs who played recognized learning roles for most of their adult lives, which was much preferable to unemployed idleness, or worse.

A person who contracts a bodily affliction that limits his or her going out of the home might have various of his/her role activities and role associates come into the home in order to continue the role activity there. For instance, a member of a book study circle could regularly host the meetings in his or her own home. This involves both competency and image measures.

Sometimes, the preservation of even a single valued role can be life-deciding to a person. For instance, when an aged senile woman is gravely ill in the hospital, the fact that she is someone's beloved sister, aunt, friend, or fellow church member—and making this fact known—may protect the person against decisions to cease treatment or even to "put her out of her misery."

Averting entry into (additional) devalued roles. Regardless of whatever valued roles they may hold and be able to maintain, some people are at high risk of entering, or being cast into, new roles that are devalued, perhaps even in addition to whatever devalued roles they already hold. It is usually much easier to prevent such entry than to reverse it. High consciousness is of crucial importance here, particularly about which devalued roles a party is at risk of being thrust into. Thus, the previous inventory of risk factors once more becomes very helpful.

For instance, impaired persons are often at risk of entering the sick role or chronic patient role. Such roles might be staved off by such competency-supporting measures as good health regimens, proper diet and exercise, and being cautious about taking recourse to certain health and mental services that are apt to ensnare a person into long-term patienthood.

Mentally impaired people are often at risk of being cast into the role of object of ridicule. Thus, it is especially important to avoid associating such a person with clown imagery (an image action) and to minimize the likelihood that the person develops a habit of speaking and acting in peculiar ways in order to gain attention by amusing others (a competency action). One can also alert others to the importance of *not* reinforcing such behavior from the person (both an image and competency action).

Enabling either entry into positively valued new roles or the regaining of valued roles previously held. Often, it is possible to enable people to enter new roles that are valued (role acquisition) or to regain valued roles they had once held but have since lost (role recovery). Such a valued role may be an addition to one or more valued roles already held, or it may be a replacement for one or more valued roles already lost or about to be lost. However, for some people, it could be the first or even only valued role!

One might, for example, enhance the athletic prowess of a retarded adolescent so that he or she can compete with nonimpaired age peers in one or more kinds of normative community athletic contests and, thus, assume the roles of athlete, competitor, and perhaps even champion. An example is a man with Down's syndrome in New York who competes in regular weight-lifting tournaments (Good Press, 1996). Most retarded people can be taught to read and, therefore, assume roles for which reading is a requisite in school, at church, in sports, etc. An example of the power and importance of a valued image-related role acquired via a personal relationship is a retarded man with Down's syndrome who became a friend of Wayne Gretzky, one of the best hockey players of all times, and a hero, especially to Canadians, for much of the 1980s and 1990s. For years, he was almost always at Gretzky's side and, as a result, was afforded multiple other valued roles and many of the good things of life.

Many actions in this category will involve both image- and competency-enhancement, such as enabling a child to take on the valued role of student, an adult to enter the role of worker or employee, or someone to enter the role of church choir member. If a child, rejected at birth as impaired or disfigured, and floating chaotically through the child welfare system, could be ensconced via adoption into the valued role of cherished son or daughter, this would first of all have a profound image impact and, in most cases, eventually also vast competency benefits.

Sometimes, a person can recapture a valued role once held but then lost. For instance, a person of valued status who has committed an offense and served time in prison might be enabled to reestablish a respectable citizen role—which is most likely to be an image issue. Very relevant to many retarded people is that valued family roles may have been lost, perhaps because of discontinuities in family contacts or break-up of the family, institutionalization, or imprisonment. But it is often possible to restore a person's family ties and roles, so that the person becomes once again a valued brother or sister, aunt or uncle, grandparent or grandchild, perhaps even a breadwinner for an impoverished relative, etc. Whatever other benefits come with having family relationships, positive imagery is usually one of them.

In regard to this role goal, and the first one of valorizing the positive roles already held, it is not always possible to craft what I had called a "big" positive role for devalued people, or it may take a long time to do so. Generally, it is much easier to craft small positive roles, and it may even be possible to craft several of them in relatively short order.

Extricating a party from currently held devalued roles. There are all sorts of things that can be done to help people to escape whatever devalued roles they are in. Actually, this is a function that is explicitly claimed (though rarely in role theory terms) by many human services: to pursue the rehabilitation of prisoners, people addicted to drugs, the illiterate or unintelligent, the unemployed, the bodily impaired, victims of stroke, etc., etc.

For instance, where an impaired adult is caught in an eternal child role, one might be able to help that person to escape that role by engaging in adult activities, developing adult interests and hobbies, etc. Where a person has been caught up in the object of ridicule role, it is important to weaken any habits the person may have of drawing attention by being ridiculous and playing the clown, and to structure the person's environment (settings, activities, other people, and their interactions, etc.) so as not to elicit jester-type behavior. One might recruit allies who model dignifying behavior toward

that person, and who rebuke others who try to play jokes on the person. All these measures are mostly focused on competencies, but can be expected to have image benefits.

Reducing the negativity of a devalued role currently held. Most people occupy some—usually small—negative roles at least at some time during their lives, even if these negative roles are overshadowed by the positive ones they hold. For instance, we are all lawbreakers at various times, or dawdlers, or in a sick role, and on and on. Unfortunately, devalued people often have not only *many* negative roles, but these may also dominate their lives. So aside from whatever other role goals might be pursued, the negativeness of one or all of a party's negative roles might also be reduced. This is not as good as fully extricating a person from a devalued role, but it is an improvement. Indeed, in a great many instances, a party is so deeply embedded in major negative roles that the best that one may be able to do is to take some of the negativeness out of one or some of them.

Examples relevant to imagery are that a person in the sick role might be dressed every morning rather than lying or sitting around in bed clothes all day; medical devices and prostheses not in immediate use might be kept out of sight; the person's sick room might be made to look like an ordinary bedroom rather than a hospital room; and some medical or prosthetic devices can be made to look less sterile, less mechanical, and more attractive (e.g., if one uses a motorized wheelchair for getting around, it would be less likely to evoke sick role associations if it resembled a golf cart).

There are also innumerable instances in which the acquisition of a new competency can diminish the negativity of one's devalued role. For instance, the more a person with a major medical condition, and clearly in the role of a sick patient, can learn to self-administer the required treatments and to take care of his or her condition, the less dominant will the sick role be in the minds of observers.

Exchanging currently held devalued roles for less devalued new ones. Different from upgrading a devalued role is to enable a party to exchange one devalued role against a new one that is less devalued. For instance, a retarded person who is presently seen in the very negative role of a menace, an animal, or otherwise as nonhuman, would be vastly less endangered by being seen in the less negative role of an eternal child. A physically impaired or elderly person who is engaged in childish activities all day at a segregated "day activity center" could instead be enrolled as a worker in a segregated work site, such as a sheltered workshop. The segregated environment is still devaluing, but the totality of the picture—an adult work role, even if the work, the setting, and the fellow workers are not very valued—is likely to be *less* devalued than childish activities with child-imaged associates in a child-imaged setting.

Another example, which probably involves both image- and competency-enhancement, is to enable an impaired adult to take on at least part-time "real" work for a few hours or a few days a week, and do so even if the work is not well-paid—or not paid at all. A person who holds a job that is negatively imaged might be helped to find another job that is less devalued.

In regard to this strategy, and the previous one of enabling entry into new valued roles, it is very important to note that there are innumerable valued work roles for adults that are not paid, but, nonetheless, status-improvement and other benefits can be achieved through them.

Of course, one should not aim to exchange one devalued role for a less devalued one if one can do even better and escape the devalued role altogether, or exchange it for a valued one.

Pointers About the Pursuit of Any of the Role Goals

One can now say some more things about the pursuit of any and all of the aforementioned role goals, and the respective means for pursuing them.

1. One will often want to pursue several of the role goals at once.
2. Holding one valued role often leads to others, a small valued role can sometimes serve as a springboard to a bigger or larger one, and relational roles often serve as mediators to other (including competency-exercising) ones.
3. However, one trap to avoid is trying to inflate small positive roles already held into grotesque proportions, perhaps also at the expense of enabling entry into new positive roles. For instance, a small positive role (such as storyteller) that the person has been holding may get enlarged beyond its normative prominence, so that the person becomes obnoxious to others or an object of ridicule by prattling and telling stories all the time. So what could have been a positive role had it remained small becomes abnormal and inappropriate. At best, it "ghetto-izes" the person into one single positive role, much as these days, some retarded people get ghettoized into only the self-advocate role.
4. Selecting the most role-valorizing measure can be very tricky when either different SRV goals or means compete with each other, or an SRV goal based on a certain value competes with another goal that has its rationale in other values. In fact, it is not uncommon for an image goal to compete with a competency goal, as when a competency-enhancing prosthetic device detracts from a person's positive image. Although there are principles for resolving such conflicts, these situations can be complicated and can scramble people's minds. A very common example of a clash of goals (and possibly values) occurs when a measure that would role-valorize a party within that party's larger society would not do so within that party's racial, ethnic, or religious subculture, or vice versa. This can be particularly wrenching when a person wants to belong to one (sub)culture but then would have to be and do certain things that draw devaluation and wounding from the other.
5. In regard to most of the above strategies, it is crucially important that the positive roles that a person holds are made known, or better known, to others. After all, the benefits of SRV depend first on how other people perceive a party, and derivatively, based on these perceptions, what they decide to do to and for that party. If they do not know the valued roles a person holds, then they may not accord certain positive things to the person.
6. Similarly, it can be of decisive importance that observers perceive a party's valued *activities or functions* in terms of very clearly established, identifiable and positive social role identities and concepts. Otherwise, the perceivers may not respond in a way that brings benefits to the party at issue. And in order for other people to thusly perceive, they may first have to have such activities translated to them into valued role terms. For instance, people will be much less impressed when they are told that an impaired person grows flowers (which is phrased in terms of an activity) than if they are told that that person is a rose-gardener, a member of a gardening club, and a flower-seller to a local market—all things that are roles; a person who performs helpful acts to neighbors can be interpreted as a good neighbor; etc. Of course, in the translation process, one needs to keep in mind the earlier caveat about not being deceptive.

The Potential Contribution of Different Parties to the Role-Valorization of Devalued People at Various Levels of Social Organization

I have said very little about who might do the work of role-valorization, but the fact is that almost all involved parties can do some of it: devalued people themselves, their families, other personal associates, advocates and allies, servers, service agencies, government, the media, etc. Where the intended beneficiaries are not in a good position to act effectively on their own behalf (usually because of impaired competency or reduced standing), then actions on their behalf by others become especially important.

Also, different parties may be particularly well-situated to take actions relevant to either imagery or competency and/or on one or more of four distinct levels of social organization: that of the individual person, the levels of primary and intermediate social systems, and the societal level overall, as charted out in Wolfensberger (1998).

In the pursuit of even a very specific image or competency enhancement, one may be able to do things on several or all levels of social organization, and even without requiring any changes from the intended beneficiary—a fact that many people fail to understand. For example, adding raised letters and numbers, or Braille signs, to the control panel in an elevator enables blind people who can already read Braille to be more competent using the elevator and getting about. In certain states, literacy is not a requirement for a license to operate a truck, but illiterate truck drivers disproportionately run their trucks into the overheads of bridges because they cannot read (or are not in the habit of reading) the maximum height warnings. Merely restricting the licenses of such truck drivers to driving trucks of lower height

would reduce their accident rate and, hence, improve their performance, which in SRV is subsumed under the competency construct.

Furthermore, in this brief presentation, relatively little has been said about the vast number of measures one could pursue on higher systemic levels, especially the societal one. However, two things should be clear. (a) There is a strong feedback loop between changes in or by individuals, groups, and classes and changes in and by society. (b) Efforts to change larger social systems may have more pay-off but could take a very long time—and could fail, whereas one has vastly better prospects at early success on the scale of individuals, groups, specific agencies, etc. Also, if societal change is one's goal, one should use appropriate, and multiple, social change strategies, only some of which are SRV measures.

Further Resources on Social Role Valorization

The literature on SRV and the normalization principle is too vast to be dealt with here. A great deal of it is reviewed in Flynn and Lemay (1999), who provide an overview of 25 years of history, thinking, research, and critique on these topics. Some of the earlier literature has been rendered irrelevant by the more recent evolution of SRV as sketched in this article and in more detail in a 1998 monograph (Wolfensberger, 1998). The most up-to-date lengthy written exposition of SRV is found in Race (1999), and the most detailed application to service providers is found in Wolfensberger and Thomas (1983) and is still concordant with the more recent SRV work. However, the most detailed exposition of SRV is not found in print, but at SRV training courses (from introductory to advanced levels) held mostly in the United States, Canada, and Australia. Thus, people who want to learn how to apply SRV systematically and to its full potential would have to study it in a much more substantial fashion than is provided here.

Conclusion

Role theory can be an extremely powerful tool for analyzing and explaining what happens to impaired and/or devalued people and for crafting action measures to protect them from all sorts of bad things being done to them. Surprisingly, role theory and its findings had only been moderately exploited to this purpose prior to the advent of SRV.

There is much controversy about the valuation of roles, of persons or people, and of the religious or philosophical construct of personhood. However, one thing is patently obvious: Being in roles valued by a perceiver makes it more likely that this perceiver will do good rather than bad things to and for one. Thus, all that has been covered boils down to putting good things—or at least, less worse things—about some person, group, or class into the minds of those others who are in a position to do good (or less worse) things to them. If people have and hold good things in their minds about others, they are more likely to do good things to them, just as if they hold bad things in their minds about and towards others, they are likely to do bad things to them. Relatedly, one could view SRV as a way of helping people to do what they really should want to do, and as a way of working toward a society in which (in the words of the French personalist Peter Maurin, 1997) it is easier for people to be good. The widespread practice of SRV would accomplish this by making it easier for people to value others, or to at least devalue them less.

However, one could take away some wrong ideas from this extremely short presentation. For instance, although SRV is a rather high-level conceptual scheme, and a parsimonious one at that (in being able to point to a vast number of actions on all levels of social organization and to incorporate the theorizing and findings of many other empirical theories), it has its limitations, as do all schemata. These are not detailed in this short article, but no one should be surprised that SRV will not prevent wars, defeat disease, eliminate poverty, correct all invalid stereotypes, heal all wounds, or even eliminate mental retardation or make it a valued condition.

Finally, I want to emphasize again that even though SRV is the practical application of the knowledge of social science, such an application must be guided by values—and, therefore, some form of *de facto* religion. Social Role Valorization mines a wide range of sociology and psychology, it explains an entire range of phenomena around social valuation and devaluation, it predicts what will happen to people when they are subject to certain valuing or devaluing conditions, and it offers guidance as to what one might be able to do about any of this if one so chooses. But whom one decides to value or devalue, and for whom one decides to seek more positive roles, valuation, and life experiences in society, and how far one wants to pursue this—these are all *de facto* religious decisions, not scientific ones, as explained in more detail in Wolfensberger (1995).

References

Berkson, G. (1988). All people have personal assets. *Mental Retardation, 26*, 71–74.

Flynn, R. J., & Lemay, R. A. (Eds.). (1999). *A quarter-century of normalization and Social Role Valorization: Evolution and impact*. Ottawa, ON: University of Ottawa Press.

Flynn R. J., & Nitsch, K. E. (Eds.). (1980). *Normalization, social integration, and community services*. Baltimore: University Park Press.

Good press. (1996). *Down Syndrome News, 20*(9), 115.

Lemay, R. A. (1999). Roles, identities, and expectancies: Positive contributions to normalization and Social Role Valorization. In R. J. Flynn & R. A. Lemay (Eds.), *A quarter-century of normalization and Social Role Valorization: Evolution and impact* (pp. 219–240). Ottawa, ON: University of Ottawa Press.

Maurin, P. (1997). *Easy essays*. Rifton, NY: Plough.

Nirje, B. (1969). The normalization principle and its human management implications. In R. Kugel & W. Wolfensberger (Eds.), *Changing patterns in residential services for the mentally retarded* (pp. 179–195). Washington, DC: President's Committee on Mental Retardation.

Race, D. (1999). *Social Role Valorization and the English experience*. London: Whiting & Birch.

Wolfensberger, W. (1972). *The principle of normalization in human services*. Toronto: National Institute on Mental Retardation.

Wolfensberger, W. (1980). The definition of normalization: Update, problems, disagreements, and misunderstandings. In R. J. Flynn & K. E. Nitsch (Eds.), *Normalization, social integration, and community services* (pp. 71–115). Baltimore: University Park Press.

Wolfensberger, W. (1983). Social Role Valorization: A proposed new term for the principle of normalization. *Mental Retardation, 21*, 234–239.

Wolfensberger, W. (1988a). Common assets of mentally retarded people that are commonly not acknowledged. *Mental Retardation, 26*, 65–70.

Wolfensberger, W. (1988b). Reply to "all people have personal assets." *Mental Retardation, 26*, 75–76.

Wolfensberger, W. (1995). An "if this, then that" formulation of decisions related to Social Role Valorization as a better way of interpreting it to people. *Mental Retardation, 33*, 163–169.

Wolfensberger, W. (1998). *A brief introduction to Social Role Valorization: A high-order concept for addressing the plight of societally devalued people, and for structuring human services* (3rd rev. ed.). Syracuse, NY: Syracuse University, Training Institute for Human Service Planning, Leadership & Change Agentry.

Wolfensberger, W., & Glenn, L. (1973). *Program analysis of service systems (PASS): A method for the quantitative evaluation of human services: Field manual* (2nd ed.). Toronto: National Institute on Mental Retardation.

Wolfensberger, W., & Glenn, L. (1975). *Program analysis of service systems (PASS): A method for the quantitative evaluation of human services: Field manual* (3rd ed.). Toronto: National Institute on Mental Retardation.

Wolfensberger, W., & Thomas, S. (1983). *PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals): Normalization criteria and ratings manual* (2nd ed.). Toronto: National Institute on Mental Retardation.

Received 3/17/99, first decision 6/28/99, accepted 7/3/99.
Editor-in-Charge: John O'Brien

Author: WOLF WOLFENSBERGER, PhD, Director, Training Institute for Human Service Planning, Leadership, and Change Agentry, Syracuse University, 230 Euclid Ave., Syracuse, NY 13244-5130.

Appendix C

SYRACUSE UNIVERSITY
TRAINING INSTITUTE FOR HUMAN SERVICE PLANNING, LEADERSHIP AND CHANGE AGENTRY
805 South Crouse Avenue
Syracuse, New York 13244-2280
Telephone 315-443-4264

Revised February , 1989;
June, 1990
September, 1995

OVERVIEW OF "PASSING": A NORMALIZATION/SOCIAL ROLE VALORIZATION-BASED HUMAN SERVICE EVALUATION TOOL

Introduction

Starting in the summer of 1979, the above Training Institute (TI) developed a new evaluation instrument based on the implications of Social Role Valorization (Wolfensberger, 1983b, 1984, 1985; Wolfensberger & Tullman, 1982), the successor to what was known as the principle of normalization (Wolfensberger, 1972, 1980). This instrument is called PASSING, which stands for Program Analysis of Service Systems' Implementation of Normalization Goals (Wolfensberger & Thomas, 1980, 1983). It is partially derived from the PASS (Wolfensberger & Glenn, 1973, 1975) method of service evaluation, which stands for Program Analysis of Service Systems. PASSING substantially replaces PASS. The residual uses of PASS are described in a separate flyer on it that may be requested from the Training Institute, free of charge.

PASSING's Purposes

PASSING was designed to try to meet the need for an evaluation method which would be able to do the following.

1. Assess the quality of human services in relation to their adherence to Social Role Valorization (SRV) after normalization had been reconceptualized as SRV. SRV posits as the most important goal of service the establishment of valued social roles for people who are societally devalued or at value-risk. However, the term normalization rather than SRV is still encountered in PASSING, because the new term SRV, to reflect the new insights, had not yet been coined when PASSING was at the printer's. PASSING thus incorporates the SRV concept while still using some old normalization language. PASSING assesses only those aspects of service quality which reflect a program's adoption and implementation of SRV.

2. Teach and explicate SRV and its implications very thoroughly and specifically. PASSING is the most extensive printed resource so far on the SRV concept and its implications.

3. Be universally applicable, i.e., applicable to all, or at least most, services to virtually any group of people.

4. Have content, format, and procedures that would enable most motivated, literate and reasonably intelligent people, including ordinary citizens and service recipients, to learn SRV principles and apply them in the evaluation of human services.

5. By virtue of being made accessible to larger numbers of people (no. 4 above), enable agencies and localities to train a sufficient number of evaluators to be able to conduct regular evaluations of local services. It should thereby be more feasible to adopt PASSING than PASS in a given locality as an instrument for regular, ongoing, and repeated evaluations of local services of any type, provided that PASSING training were available in the area or nearby on a routine basis with PASS, this has been an obstacle because the amount of training required to bring people to competency as PASS evaluators has been more than most locales could reasonably undertake, especially on an ongoing basis, so most agencies that wanted to use PASS have had to depend extensively on recruitment of outside evaluators, which greatly increased evaluation costs.

6. By enabling a significant proportion of people access to systematic service evaluation with this instrument, local change agents would be able to foster greater understanding and acceptance of SRV ideals among local decision-makers and the citizenry.

PASSING's Characteristics

Altogether, there are 42 "ratings" in PASSING, i.e., 42 separate criteria derived from SRV against which a service's performance would be measured. (In PASS, there were 50 ratings, 34 of which were in the normalization category.) These 42 criteria are organized in PASSING into the following 2x4 schema.

		SERVICE FEATURES BEING ADDRESSED	
		FEATURES RELATED PRIMARILY TO CLIENT SOCIAL IMAGE ENHANCEMENT	FEATURES RELATED PRIMARILY TO CLIENT COMPETENCY ENHANCEMENT
HUMAN SERVICE DOMAINS BEING ASSESSED	PHYSICAL SETTING	11 Ratings	6 Ratings
	SERVICE-STRUCTURED GROUPINGS & RELATIONSHIPS	7 Ratings	6 Ratings
	SERVICE-STRUCTURED ACTIVITIES & OTHER TIME USES	3 Ratings	3 Ratings
	MISCELLANEOUS/OTHER	6 Ratings on language, symbols, & images	no ratings as yet

All ratings in PASSING are categorized as to whether they primarily affect clients' image or personal competencies; these are the two major goals of SRV. Ratings are further subdivided within these two major categories into one of four service domains: physical setting of service; service-structured groupings and other relationships among people; activities and other uses of time within a service; and miscellaneous. There are thus eight potential categories into which a PASSING rating might fall.

Each of the 42 ratings is located in one of the above cells, depending on (a) whether it most affects clients' social image or personal competency, and (b) the service action or domain through which it may be accomplished.

Each rating in PASSING consists of five sections:

1. A narrative explanation of the rating issue, called "General Statement of the Issue."

2. A "Rating Requirements and Examples Chart," which has four columns: one contains a brief statement of the rating issue and focus; one gives one or more examples of the rating principle as actualized in normative society; a third gives one or more examples of the rating principle as actualized in hypothetical human service situations; and the last provides one or more examples of human service violations of the rating principle.

3. A "Differentiation From Other Ratings" section, which explains how the rating at hand differs from other ratings with which it is most likely to be confused.

4. A chart entitled "Suggested Guidelines for Collecting and Using Evidence," which lists typical sources of evidence for the rating, some key questions that must be answered in order to make a judgment on the rating, and some important and often overlooked considerations in regard to the rating.

5. Criteria for a continuum of five "levels" of service performance (explained below), called "Criteria and Examples for Rating Level Assignment."

Each rating in PASSING has five levels, i.e., statements about a continuum of service quality and service performance on the particular issue assessed by the rating. Each level represents the same degree of service quality across all ratings. That is, Level 1 stands for the same level of quality on all 42 ratings; Level 2 stands for the same level of quality on all ratings; etc.

The rating levels are structured to form a balanced continuum, where the lowest level (Level 1, atrocious performance) represents the opposite of the highest level (Level 5, the "attainable ideal"), the intermediate levels (Levels 2 and 4) represent opposites of each other, and the middle level (Level 3) -- the fulcrum of the balance-- represents a service performance that is a balance of both strengths and shortcomings, so that the good and the harm done cancel each other out. The percentages of weight given to a particular rating are distributed the same way (within rounding error) across the five levels of each rating. Thus, each Level 1 = -100% of the weight assigned to a rating, each Level 2 = -70%, each Level 3 = 0%, each level 4 = +70%, and each Level 5 = +100% of the weight assigned to a rating.

Level statements of service performance in PASSING are phrased in terms of the <u>likely</u> impact that service practices will have on clients' image or competencies, because it cannot always be known with certainty that a particular outcome in terms of denigration or enhancement of clients' image or competencies was caused by any one particular service feature.

PASSING's Relationship to Other Materials

PASSING-related materials are published in several volumes, some of which are equally usable with PASS.

1. The core of the series of PASSING-related publications is the <u>Normalization Criteria and Ratings Manual</u>, which currently also serves as the major text on SRV. It is available from the Citizen Advocacy Office of Onodaga County (650 James St., 3rd floor, Syracuse, NY 13203, USA;

telephone 315/472-9190). This manual contains a brief introduction to, and overview of, SRV; discussion of major SRV/normalization issues and goals; and narrative, principles, examples, and guidelines for each of the 42 ratings that comprise the instrument.

2. The French edition of PASSING was published in 1989, and is entitled PASSING (Programme d'Analyse des Systemes de Services Application des Buts de la Valorisation des Roles Sociaux): Manuel des criteres et des mesures de la valorisation des roles sociaux. (2ieme ed.) This version of PASSING incorporates some improvements over the original English version. It is available from: Les Communications Opell, 665 Bathgate Dr. #2112, Ottawa, Ontario K1K 3Y4, Canada; phone 613/749-6181.

3. Guidelines for Evaluators During a PASS, PASSING, or Similar Assessment of Human Service Quality. This is essential for the conduct of a valid and reliable assessment. It provides instructions to evaluators on how to prepare for an assessment, and how to conduct themselves at each stage of an assessment. Therefore, it is imperative that people obtain this monograph if they will be participating in a PASSING or PASS assessment, or if they want to become knowledgeable about PASSING and/or PASS for other reasons.

Quantity discounts on books are available from all the above vendors.

As of mid-1990, a small monograph-length overview of SRV is in preparation. It constitutes a more extensive introduction than appears in the PASSING Manual, and could be useful as a preparation for learning PASSING, or for other purposes of introducing people to SRV. It is being published in Switzerland, and is available in English, French, German, and Italian. Contact the Training Coordinator at the TI for more information.

The Training Institute also has available a number of materials useful for teaching people SRV and PASSING. These include a slide set of approximately 1000 slides, and lecture modules for conducting a standard 2 or 3 day introductory SRV workshop and a 4 or 5 day introductory PASSING workshop. However, these lecture materials are only released under strictly controlled conditions. Contact the Training Coordinator at the TI for more information on the availability of these various teaching materials.

Several other monographs are envisioned (some already in draft form), but not yet available, including: PASSING Handbook, which will be comprised of background/explanatory material on how the instrument is structured, how to adapt the instrument for use in extraordinary circumstances, explanations of how the ratings were weighted, etc.; guidelines for written and oral reporting of assessment findings; the arrangements for, and follow-up on, an assessment with an agency; a manual for PASS/PASSING trainers; a PASS/PASSING theory, research, and utilization series; etc. This modular approach to publication will permit users to buy only those parts that are of use or interest to them, as well as permitting the separate revision of modules so that users do not have to replace the other parts as well.

A bibliography on SRV, PASSING, and PASS is available from the Training Institute: write for information on obtaining this bibliography and its current cost.

Special instruction on how to use PASSING in combination with parts of PASS are available from the Training Institute for $10.

The development of the first edition of PASSING was carried out during 1979-1980 under a contract between the TI and the County of Dane (Madison, Wisconsin) Developmental Disabilities Services Board. This edition was never available for general distribution. The revision and continued development of PASSING was supported by a grant from the Research Foundation of the National Easter Seal Society, from which came a second improved edition that was published for general use by the National Institute on Mental Retardation (now called the G. Allan Roeher Institute) in Toronto, Ontario (publishers of the Normalization and PASS texts), and PASSING training is now available through several bodies in a number of countries around the world (information on request).

For further information about PASSING, or PASSING training materials or workshops, please contact the Training Coordinator at the Training Institute.

References

1. Wolfensberger, W. (1972). The principle of normalization in human services. Toronto: National Institute on Mental Retardation.

2. Wolfensberger, W. (1980). The definition of normalization: Update, problems, disagreements, and misunderstandings. In Flynn, R.J., & Nitsch, K.E. (Eds.), Normalization, social integration, and community services. Baltimore: University Park Press. Pp. 71-115.

3. Wolfensberger, W. (1983a). Guidelines for evaluators during a PASS, PASSING, or similar assessment of human service quality. Toronto: National Institute on Mental Retardation.

4. Wolfensberger, W. (1983b). Social role valorization: A proposed new term for the principle of normalization. Mental Retardation, 21(6), 234-239.

5. Wolfensberger, W. (1984). A reconceptualization of normalization as social role valorization. Canadian Journal on Mental Retardation, 34(2), 22-26.

6. Wolfensberger, W. (1985). Social Role Valorization: A new insight, and a new term, for normalization. Australian Association for the Mentally Retarded Journal, 9(1), 4-11.

7. Wolfensberger, W., & Glenn, L. (1975, reprinted 1978). Program Analysis of Service Systems (PASS): A method for the quantitative evaluation of human services. Handbook. Field Manual. (3rd ed.) Toronto: National Institute on Mental Retardation. (Earlier editions published in 1969 and 1973.)

8. Wolfensberger, W., & Tullman, S. (1982). A brief overview of the principle of normalization. Rehabilitation Psychology, 27(3), 131-145.

9. Wolfensberger, W., & Thomas, S. (1980). PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals). (1st ed.) Syracuse, NY: Training Institute for Human Service Planning, Leadership & Change Agentry.

10. Wolfensberger, W., & Thomas, S. (1983). PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals): Normalization criteria and ratings manual. (2nd ed.) Toronto: National Institute on Mental Retardation.

11. Wolfensberger, W., & Thomas, S. (1989). PASSING (Programme d'Analyse des Systemes de Services Application des Buts de la Valorisation des Roles Sociaux): Manuel des criteres et des mesures de la valorisation des roles sociaux (2ieme ed.) (M. Roberge, Trans.; J. Pelletier, Adap.) Toronto: Institute G. Allan Roeher & Les Communications Opell. (Original work published in 1983.)

Vendors

References number 1, and 7 are available from: G. Allan Roeher Institute, Kinsmen Building, York University Campus, 4700 Keele Street, Downsview, Ontario M3J 1P3, Canada; telephone 416/661-9611.

References number 1, 3, 7, and 10 are available from: Person-to-Person/Citizen Advocacy, 650 James Street, 3rd floor, Syracuse, New York 13203; telephone 315/472-9190.

Reference number 11 is available from: Opell Communications, 2021 Quincy Avenue, Gloucester, Ontario K1J 6B4, Canada; telephone 613/749-6181.

References number 2, 4, 5, 6, and 8 are available from: Syracuse University Training Institute, 805 South Crouse Avenue, Syracuse, New York 13244-2280; telephone 315/443-4264.

Call or write to each vendor directly for an up-to-date publication and price list.