

Deinstitutionalization of People With Developmental Disabilities: A Review of the Literature

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ABSTRACT

Ontario has recently closed its last 3 institutions for persons with developmental disabilities. Very little research has been conducted on Canadian deinstitutionalization projects, and the impacts and bona fides of such endeavours have not been well documented in Canada. However, the closing of institutions has occurred in most Western jurisdictions and has been the subject of much research in Australia, the United Kingdom, and the United States. Although community services are of variable quality, this literature review suggests that the Ontario plan to close institutional facilities in favour of community-based residential services will be of general benefit to former institutional residents.

Contemplated from a distance, deinstitutionalization seems a benign and essentially decent government policy that high-mindedly brings back to the community those individuals with developmental disabilities who have lived through years of segregation in institutional settings. However, when institution closures hit closer to home, the reactions are much more visceral (Wente, 2005). Deinstitutionalization continues to be controversial (Parish, 2005; Taylor, 2001). Indeed, even in academia—among researchers—challenges arise over the integrity of research and the conclusions drawn (Felce 2006; Taylor & Wyngaarden Krauss, 2006; Walsh & Kastner, 2006). Moreover, ongoing litigation surrounds the closure of institutional settings (Ferleger & Boyd, 1980; Smith, 2005). There are, of course, legitimate interests at play here: Institutional closures may mean the loss of jobs, with a concomitant impact on local economies. Institution residents often have complex needs and have resided in such settings for decades, and many families are concerned for their welfare. For the people involved, and for those charged with welcoming former institutional residents, what are the challenges, and what might be the expected outcomes?

In Canada, the deinstitutionalization of persons with developmental disabilities has been promoted by the federal government since the early 1980s with the publication of *Obstacles* by the House

of Commons Special Committee on the Disabled and the Handicapped (Smith, 1981). In 2006, a total of 3,873 individuals were still living in institutional settings across Canada (Institution Watch, 2006). In Ontario, the provincial government made a commitment in 1987 to close the 16 residential institutions for adults with developmental disabilities within 25 years (Ontario Government, 2004). In September 2004, the province announced that the last three institutions, housing approximately 1,000 individuals, would close by March 31, 2009. In all, some 7,000 individuals have been transferred to community settings with the closure of Ontario's facilities.

Deinstitutionalization is not a policy particular to Canada. In the United States, institutional beds have gone from 194,650 in 1967 to 48,496 in 1999 (Taylor, 2001). In England, institutional beds have decreased from over 51,000 in 1976 to under 4,000 in 2002 (Emerson, 2004). Australia has experienced a similar trend (Young, Ashman, Sigafos, & Grevell, 2001). In addition, people with developmental disabilities are increasingly residing in smaller residences. In 2006, fewer than 30% of adults in out-of-family placements in the United States resided in homes with more than six residents, and the number of individuals living in homes with fewer than four residents increased from 18,304 in 1996 to 195,450, in 2006 (Prouty, Lakin, & Coucouvanis, 2007).

There is much and varied research on deinstitutionalization in the English-speaking world, but very little recent research in Canada. This present review was carried out by the administrator of an Ontario agency that is active in welcoming former institution residents. The author has published work on social role valorization (Lemay, 1995, 1999, 2006; Flynn & Lemay, 1999), a theory concerned with the enhancement of the social image and competencies of persons—including those with developmental disabilities—who are otherwise devalued. This theory is particularly sympathetic to community living.

This review expands and updates one by Kim, Larson, and Lakin (2001), who reviewed U.S. research from 1980 to 1998 on the deinstitutionalization of people with developmental disabilities; their review extended an earlier study conducted by Larson and Lakin (1989). Kim et al. (2001) reported especially on adaptive and challenging behaviour domains, concluding that a move to the community was generally associated with an improvement in the former and a reduction in the latter. This review will update their findings and broaden the discussion to include other areas of concern—parent involvement, mortality, cost benefit, quality of life conditions and experiences, and social relationships—that are viewed as relevant to the Ontario initiative and discuss the challenges associated with the move to community living.

THE METHOD OF THIS REVIEW

The methodology of the present review is based on that of Kim et al. (2001). They reviewed 250 international studies, and their criteria (studies had to examine the move of a minimum of five adults from institutions to community residences through pre–post data gathering, basic demographic information, and measurements of adaptive and/or challenging behaviour) yielded 25 longitudinal studies and 12 contrast study groups that included approximately 3,800 participants. Kim et al. identified five

important periodicals for this type of research: *American Journal on Mental Retardation*; *Education and Training in Developmental Disabilities* (formerly *Education and Training in Mental Retardation*); *Journal of the Association for Persons with Severe Disabilities* (now called *Research and Practice for Persons with Severe Disabilities*); *Journal of Intellectual and Developmental Disability*; and *Intellectual and Developmental Disabilities* (formerly *Mental Retardation*). The present review replicates their methodology except that it excludes dissertations, includes studies beyond the U.S., broadens the selection criteria of studies to encompass a range of concerns affecting people with developmental disabilities, and covers the period January 1999 to October 2007.

A computer search of PSYCHINFO and ERIC databases, a manual review of the above periodicals, and a review of article bibliographies identified studies that met the modified criteria. Although some publications may have been missed (this was not an exhaustive undertaking), this review covers the most likely references one would need in order to grasp the current state of the research. The studies reviewed here illuminate ongoing controversies, including issues that were not covered by Kim et al. (2001). Because of the lack of reference material from Canada, it is assumed that research carried out in the United States and elsewhere would be replicable in Canada. Special attention is given to the key issues and outcomes reported in the literature that might be relevant to the current Ontario initiative. The analysis is generally informed by normalization and social role valorization theory (Lemay, 1995, 1999, 2006; Wolfensberger, 1972, 1983, 1998); thus the findings may be applicable to other populations with severe disabilities.

PARENTS AND DEINSTITUTIONALIZATION

Parents of institutional residents play a key role in making or breaking deinstitutionalization projects (Parish, 2005). However, parents and family members of institutional residents, long dependent on the permanence of the institution, may greet such important changes with suspicion. In Australia, Tabatabainia (2003) found that parents, fearing a negative impact on family life and concerned for the welfare of their son or daughter, often opposed deinstitutionalization. The author concluded that the authorities had not adequately prepared families for the deinstitutionalization process or educated them about normalization, the expected benefits, and services available in the community.

In other studies where families were surveyed (Grimes & Vitello, 1990; O'Brien, Thesing, Tuck, & Capie, 2001; Spreat & Conroy, 2002), one common finding is that family members are often initially against deinstitutionalization, but they eventually become reconciled and may even become very supportive of community living. Indeed, family members contact their relatives much more frequently after deinstitutionalization, and the frequency of contacts remains higher even after several years of placement in the community (Spreat & Conroy, 2002).

Even though family members do not always hold adaptive beliefs or attitudes about their son/daughter or brother/sister (Wolfensberger, 2003), family presence and participation in the person's life can be an important safeguard for security and service quality (Spreat & Conroy, 2002; Wolfensberger, 2003; Young & Ashman, 2004). Planning for such involvement can be an important element in success.

MORTALITY

Two controversial American studies (Strauss, Eyman, & Grossman, 1996; Strauss, Kastner, & Shavelle, 1998) have suggested that individuals with developmental disabilities, particularly those with severe disabilities, have higher mortality rates in the community than in institutions. Durkin (1996) challenged the methodology of these studies. Contributors to a special issue of *Mental Retardation* (1998, vol. 36, no. 5) acknowledged the complexity of the issue and pointed out the importance of replicating the research done in other jurisdictions. Other studies have found different results: Conroy and Adler (1998) found improved survival for persons leaving the Pennhurst institution for life in the community whereas Lerman, Apgar, and Jordan (2003) found no difference between movers and stayers.

However, findings that support an increase in mortality rates should not be surprising. It is now well established that people are generally more susceptible to disease and death in the time following important life changes (House, Landis, & Umberson, 1990; Lund, Modvig, Due, & Holstein, 2000). Life changes present serious adaptational challenges that may be all the more important for individuals with serious disabilities. Therefore, such findings do not support institutionalization but rather the necessity of implementing deinstitutionalization with great care (Taylor, 2001).

ADAPTIVE BEHAVIOURS

When it comes to adaptive behaviour, deinstitutionalization research data are fairly straightforward. Some of the earliest results of such research showed that individuals made remarkable gains (Clarke & Clarke, 1954; Clarke, Clarke, & Reiman, 1958). Such findings stand as a precursor to resilience theory (Clarke & Clarke, 1998), which is particularly relevant to mental health. Kim et al. (2001) found that 26 of the 37 studies they reviewed documented improvements in adaptive behaviours in individuals taking up residence in the community, and 19 of these studies had statistically significant results. Six studies reported a deterioration of adaptive behaviours, two of which had significant results. This review did not find any studies reporting deterioration in adaptive behaviours between 1999 and 2007.

Lerman et al. (2005) studied a total of 300 institutional residents in New Jersey (U.S.) who were divided into two matched groups (150 movers and 150 stayers) for age (average age 52) and level of developmental disability. The movers showed no change in cognition, communication, and social skills. The stayers, however, had significant deterioration in these skill areas. Movers had significantly improved self-care skills, while stayers demonstrated no change. Because of their age, both groups experienced loss of mobility over the course of the longitudinal study.

Young, Ashman, Sigafos, and Grevell (2000, 2001) report on the closing of Challinor, an institution in Queensland, Australia. A group of 95 individuals were moved into the community (average age 47, with an average of 32 years in institutional care). The preliminary report of Young et al. (2000) found no significant improvement in adaptive behaviours. However, their subsequent report in 2001 found significant improvements in adaptive skills and behaviours, including choice making, improved life circumstances, and more active and involved lifestyles. Young and Ashman (2004) studied a group of 104 adults (average age 47, with an average of 26 years in institutional care) who moved from

Challinor. They were assessed once with a variety of measures prior to leaving the institution and 5 times over the 24-month period following deinstitutionalization. Most showed significant improvements in adaptive behaviour, including choice making. The group characterized as having severe to profound developmental disability did the best. Young (2006), in another comparison of two matched groups each of 30 individuals moving from Challinor to (a) small, dispersed community residences versus (b) a cluster of group residences found that both groups improved after the move from the institution; however, those who moved to the dispersed homes did significantly better.

Stancliffe, Hayden, Larson, and Lakin (2002) reported on a U.S. longitudinal study of 148 deinstitutionalized adults with developmental disabilities (average age 46.8, with an average of 29.3 years in residence) who were followed from 1990 to 1996 after leaving an institution in Minnesota. Seventy-eight adults moved to larger group home facilities (6 to 15 residents), and 70 moved to community residences for 4 persons or fewer. This study found a decline in adaptive behaviour, a “relatively rare finding” (p. 317), in the larger group residences and no change for individuals living in the smaller residences.

In New Zealand, O’Brien, Thesing, Tuck, and Capie (2001) conducted a study in 1997 measuring the retrospective perceptions of change for 54 persons who had been deinstitutionalized in 1989 (average age 48, average stay 22 years). Personnel from community agencies, family members, and nine clients with sufficient verbal skills were interviewed. The majority of staff (75%) and family members (73%) reported a positive change in the deinstitutionalized individuals. Everyone perceived significantly higher quality of life for the individuals after moving to the community. Comments from the nine clients were overwhelmingly positive.

It now seems quite clear that even for individuals with severe cognitive limitations, a move from congregate care to community living leads to a significant improvement in adaptive behaviours.

COST BENEFIT

Spreat, Conroy, and Fullerton (2005) matched samples of 174 Oklahoma residents with developmental disabilities living in the community and in an institution to compare costs and outcomes. Community living provided significantly more hours of service, and increased opportunities for vocational and community experiences, at a significantly lower cost (US\$138,720 vs \$123,384 per person per year).

In the UK, Robertson et al. (2004) measured the quality and cost of community-based residential supports for 25 people with developmental disabilities compared with a matched group of individuals who remained in institutional care. The services were assessed twice, at 20-month intervals. Annual costs per person averaged US\$115,830 in institutional care compared with US\$96,010 in the community residences. The authors concluded that community residences were more cost-effective.

Felce, Lowe, Beecham, and Hallam (2000) studied the cost and quality of service for adults with severe intellectual disabilities and challenging behaviours in Wales and England. They compared 17 individuals living in community houses with 17 individuals residing in institutions. The average age of the residents was 22 years, and all participants had severe behavioural problems. The authors found

that community staff, though less qualified, were significantly more attentive to residents (community staff spent 22.3% of their time interacting with residents versus 7.7% in institutions). Involvement in activities increased to 35% of time per week in the community from 14.2% in institutions. Residential costs, however, were significantly higher in the community, which the authors suggest is different from studies in other countries. Over a 3-month period, community service costs averaged £22,898 per person versus £11,464 in the institution.

Generally, community living seems to be more cost-effective and often less expensive than institutional care.

QUALITY OF LIFE CONDITIONS AND EXPERIENCES

Felce (1997) provides a comprehensive description of the quality of life concept, suggesting that both subjective factors and objective conditions should be included in any definition. Wolfensberger (1994) argues that the commonly used expression *quality of life* is problematic for individuals who are dependent upon others. Here I use the expression *quality of life conditions and experiences* (QLCE) in order to make unequivocal the requirements placed on service providers.

O'Brien et al. (2001), using Likert scales, reported the perceptions of parents and staff in rating the material possessions, health, productivity, intimacy, safety, place in community, and emotional well-being of deinstitutionalized individuals in New Zealand. They concluded that the person's quality of life "was judged to be significantly higher, on average, at the time of the interview than in the hospital" (p. 76).

Nottestad and Linaker (1999) and Nottestad, Stromgren, and Linaker (2001) in their two studies on the deinstitutionalization of 109 individuals reported vast improvements in living conditions. Young and Ashman (2004), Felce et al. (2000), Robertson et al. (2004), and Young et al. (2001) all documented important improvements in quality of life conditions and experiences.

Reviews of program evaluation data using PASS (Program Analysis of Service Systems; Wolfensberger & Glenn, 1975) and PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals; Wolfensberger & Thomas, 1983, 2007) that measure QLCE have consistently found that community residential services do significantly better than institutional settings (Flynn, 1980, 1999; Flynn, Lapointe, Wolfensberger, & Thomas, 1991). Though community settings do better in these studies, they do not achieve high scores of quality or excellence, averaging less than 50% of the possible score. Indeed, Perry and Felce (2005) found much variability in the quality of the living arrangements of 154 people living in 47 different community residences in the UK.

Community living seems to afford increased quality of life conditions and experiences, though much improvement is possible in community residential services.

SOCIAL RELATIONSHIPS

Institutional settings provide residents with a limited number of relationship possibilities, usually with other residents, staff, and family, and sometimes with volunteers.

Robertson et al. (2001) reported on 300 adults living in community residences who were compared with 240 adults residing in institutions (average age 45.1, average length of placement 20.1, average stay in current placement 7.4 years). The participants had an average of 5 people in their social networks (with a median of 2 and a range of 0–20), with 83% of these having staff, 72% family members, and 54% other residents; only 30% had networks that included other people. Robertson et al. concluded that irrespective of setting type, people with developmental disabilities are very isolated, suggesting that community residential services are not taking advantage of the increased opportunities to be found in community settings.

In the UK, Forrester-Jones et al. (2006) interviewed a sample of 117 men (average age 51) and 96 women (average age 56) 12 years after they had left institutional settings. The size of the average social network for these individuals was 22 people (range 3–51), with 25% being other service users, 43% staff, 14% family members, and 11% miscellaneous others. These social networks are larger than those reported in most other studies, but they are nonetheless smaller and qualitatively different than normative social networks.

Burchard (1999) conducted a Vermont study of 27 single adults with developmental disabilities, aged 23 to 35, residing in supervised apartments who were compared with a matched group (for age, gender, and community size) of 27 single, non-disabled adults. Although “there were no differences in the rate or type of activities in which the two groups engaged over a 2 week period” (p. 258), the compositions of the social networks were very different: the adults with developmental disabilities on average named half as many people in their social networks. The composition and size of their social networks remained significantly narrower than that of typical adults, and individuals with developmental disabilities did not seem to penetrate significantly into the valued social world around them. This social integration “conundrum” (Lemay, 2006) is not only a problem for people with developmental disabilities; it has also been noted among former psychiatric patients. O’Connor (2001), in her assessment of the residential situations of 73 former patients, found that they had few contacts outside of their peer group of ex-psychiatric patients. Flynn and Aubry (1999) confirmed that this situation seems to occur with regularity in the adult mental health sector.

Lemay (2006) has argued that one possible reason for this is that social interaction and eventually social relationships are mediated by the roles that one has in any given setting. Similarly, Leroy, Walsh, and Rooney (2004), in their article on elderly women with developmental disabilities living in the community, reported that residents were often unable to break out of their service structures to take advantage of the opportunities in the neighbourhood. “All of them lived in poverty and had little control or access to the small amount of money they did have. . . . These women were very dependent on the paid staff in their lives and, as a result, many of their community activities centered on what the staff wanted to do and where the staff wanted to go” (p. 438).

Role activities in more frequented settings, for instance at work, in the neighbourhood, or at a club, offer more opportunities for engaging with others, forming acquaintances and, eventually, developing friendships. Brown, Shiraga, and Kessler (2006) describe the considerable social integration of 50 individuals (average age 39.4) with significant disabilities. The authors reviewed the work histories and professional supports provided over the years (average of 18.2 years) in employment settings and

concluded that, though some meaningful relationships may occur with relative ease, it is “more common for them to develop gradually” (p. 118) and through the intervention of job coaches and other staff.

Lemay (2006) argues that the community is rich in role opportunities and relationship possibilities, but social integration requires a deliberate and well-thought-out strategy to move individuals with developmental disabilities out of their social isolation.

CHALLENGING BEHAVIOURS

There is a fair amount of debate about deinstitutionalization and challenging behaviours. As is reviewed above, studies have shown that deinstitutionalization leads to improvements in quality of life conditions and experiences, and to concomitant improvements in adaptive behaviours. However, as observed by Kim et al. (2001, p. 45), “a common argument against deinstitutionalization is that challenging behavior will deteriorate when the person moves.”

Between 5 and 15% of people with developmental disabilities exhibit severely challenging behaviours, for example, aggression and self-injury (Emerson et al., 2001); approximately two thirds of these individuals are male, and two thirds are younger adults. Moreover, Emerson et al. reported that people who exhibited the most challenging behaviours had difficulty communicating and were also the most dependent, requiring assistance in eating, dressing, and walking. Self-injurious behaviour is most often related to severe cognitive limitations, whereas aggression is related to persons with less severe disability.

Kim et al. (2001) in their review of U.S. research studies between 1980 and 1998 reported that 3 of the 12 contrast group studies found improvement in challenging behaviours for deinstitutionalized individuals when compared with individuals who stayed behind, including one study that found a statistically significant improvement. Two studies reported deteriorations that were not statistically significant, while the remaining studies “showed no significant change” (p. 45). Of the 25 longitudinal studies reviewed, 10 reported improvements (6 were statistically significant), while 6 found increased levels of challenging behaviours after the move (2 were statistically significant).

Nottestad and Linaker (1999) in their Norwegian study of 109 adults with developmental disabilities who moved to the community found that 25 people who had had no disturbances before the move acquired behavioural problems in the community, while 24 adults stopped their problematic behaviour after the move. Fifty-five people who had had behaviour disturbances in the institution continued to exhibit them after the move. Nottestad et al. (2001) then focused on a subgroup of 22 elderly adults with developmental disabilities who had moved to the community and found increases (not statistically significant) in psychiatric disorders and in behaviour problems.

Young and Ashman (2004) in their report on the deinstitutionalization of 104 older Australian adults with severe developmental disabilities found early decreases in challenging behaviours, but after 24 months, behaviours returned to institutional levels. Robertson et al. (2004) reported that methods used to control challenging behaviour were different in institutional versus community settings;

medication, physical restraint, and physical intervention were used more often in institutions, with a significantly higher risk of injuries to other residents. Stancliffe et al. (2002) found initial increases in challenging behaviours at the first assessment after deinstitutionalization; however, on subsequent reassessments, there were no differences between the levels of challenging behaviour in the institution versus the community, though use of antidepressant medication had increased in the community. Young et al. (2000) reported significant decreases in challenging behaviours among adults following deinstitutionalization, but in their subsequent report (2001) they found no significant change overall, though a subgroup of adults with less severe disabilities showed significant reductions in challenging behaviours.

Widrick, Bramley, and Frawley (1997; their study was not included in the review by Kim et al., 2001) reported on the successful transition to community living for the last 47 residents of Vermont institutions—individuals who had been identified as least likely to succeed in the community. These 14 women and 33 men, ranging in age from 27 to 88, had resided in institutions from 11 to 70 years (median 33 years). The authors comment that their study “shows that, contrary to earlier reports, a non-medical model of community placement may be effective for a group that was regarded the most difficult to serve” (p. 236).

In a small UK study, Golding, Emerson, and Thornton (2005) compared six men (average age 49.5) who moved from an institution to the community with six men (average age 32.2) already living in the community, using pre–post move measures. For problem behaviour, there was no change for the community group, but a remarkable and significant reduction of 98% for those who moved from the institution to the community. Changes were maintained at a 6-month follow-up.

The mixed results reviewed above have led to some debate and speculation on the part of researchers. On the one hand, very few studies have found evidence of the purported “relocation syndrome” or “transition shock” (Widrick et al., 1997). Though some studies have reported significant reductions in challenging behaviours of individuals who have moved to the community, a greater number still find no change, while a few have found an increase in challenging behaviours. It seems that improvements in life conditions and experiences are insufficient, in and of themselves, to produce reductions in challenging behaviours.

Marion, Touchette, and Sandman (2003) have argued that challenging behaviours might be intrinsic to severe and profound disability. They systematically observed and analyzed the self-injurious behaviour (SIB) of 45 adults living in a 900-bed U.S. facility, 84% of whom had severe to profound developmental disability. The authors found “no evidence that SIB was conditional on environmental events or on other recorded behaviors” (p. 309) and concluded that “SIB is controlled by internal or biological motives” (p. 311). However, Symons (2005) rebutted these conclusions, pointing out that there is an important difference between the stimulus-reinforcement conditions required for acquiring a behaviour and those needed to maintain it. Symons suggested that Marion et al. were possibly observing well-learned behaviours that required very little in terms of behavioural or environmental support. Marion, Touchette, Kroeker, and Sandman (2005) responded to Symons and in the end agreed that “environmental factors can influence the rate and severity of SIB. Compelling demonstrations of

environmental control of behavior with functional analytic techniques have been reported” (p. 328). Indeed, Oliver et al. (2006) have recently reported that a mere 5 minutes of social attention can greatly reduce SIB in individuals with Cornelia de Lange Syndrome.

Felce et al. (2000) and Young and Ashman (2004) argue that on the whole the staff employed in community services may not have the training required for dealing with challenging and self-injurious behaviour. There is no doubt a need to set up intensive training programs as well as specialized services to deal with challenging behaviours in the community (Nord, Wieseler, & Hanson, 1998). Burchard (1999) documented the importance of staff training, particularly in normalization-related competencies and attitudes (Wolfensberger, 1972, 1998) as a key factor in optimizing residential settings and client outcomes: “Staff competence in Normalization values, attitudes, and practices was reflected in the promotion of Normalization goals and in clients’ activities and satisfaction with their living situation” (Burchard, 1999, p. 249). Widrick et al. (1997) concurred that normalization is an important factor in reducing challenging behaviours.

CONCLUSION

On the whole, the data are compelling: People, irrespective of their degree of disability, are apt to do better in the community on most measures and do no worse when it comes to challenging behaviours. Moreover, these findings suggest a serious underperformance by community-based services, which can be addressed through systematic training approaches that teach staff and family members the attitudes and competencies required for taking advantage of community living. As Fujiura (2006) suggests, “the community must do much better” (p. 374).

However, controversy and litigation continue over the closure of institutional settings (Ferleger & Boyd, 1980; Smith, 2005). Taylor (2001) notes that institutions are dying and disappearing none too soon. Walsh and Kastner (2006) argue that the “current zeitgeist,” which they call the “community imperative” (p. 368), favours the community-based model, and Fujiura (2006) acknowledges that opposing service “philosophies” have made this research debate conflictual. The evident demise of the institutional model has only made the controversy more strident. According to Taylor, the move to the community is one of legal rights and of common decency. It is a matter of quality of life conditions and experiences.

The people with serious cognitive impairments described in much of this review depend on professional service structures. Thus the above findings might generalize to other dependent groups such as people with serious mental illness. Indeed, in the field of mental health, discussions concerning housing and the community presence of people with serious psychiatric disabilities have engendered similar dynamics and debates (Hogan & Carling, 1992; Ridgway & Zipple, 1991). Sylvestre, Nelson, Sabloff, and Peddle (2007) suggest that evidence-based arguments for community living options for individuals with serious mental illness are trumped by value-based citizenship arguments. Very simply, the institution cannot replace the community in providing individuals—including those with developmental and serious psychiatric disabilities—with the opportunities for the good life. There are no

compelling client-related arguments left for keeping people with cognitive limitations, and possibly people with psychiatric disabilities, away from their families and communities.

RÉSUMÉ

L'Ontario vient de fermer ses 3 derniers établissements résidentiels pour personnes ayant une déficience intellectuelle. Jusqu'à présent, il n'y a pas eu beaucoup de recherche sur les projets de désinstitutionalisation au Canada, et on ne peut donc pas citer une grande documentation canadienne appuyant le bien-fondé de ce genre d'initiative. Cependant, la fermeture d'institutions est chose courante dans la plupart des juridictions du monde occidentale et a été l'objet de beaucoup de recherches en Australie, au Royaume-Uni et aux États-Unis. Bien que les services communautaires soient de qualité variable, cette recension suggère que le projet de l'Ontario visant à fermer ses établissements et à favoriser des services résidentiels communautaires sera bienfaisant aux anciens pensionnaires d'établissements.

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