HISTORY OF THE LADY HOCHOY HOME

The Residential Center of The Lady Hochoy Home was established on 20th March 1961. It was established to meet the needs of children who were severely mentally retarded. Previously children with mental disability were housed at the St. Ann’s Mental Hospital together with adult patients and at the St. James Infirmary which was then called the House of Refuge.

MISSION STATEMENT

There is at present no existing mission statement of the Lady Hochoy Home. However, it is guided by that of the Trinidad and Tobago Association for Retarded Children. It reads as follows:

“To provide an environment for persons with mental retardation to enable them to achieve their full potential for integration into the mainstream of a well informed society.”

It was a visit in 1957 by Lady Hochoy, the wife of the then Governor of Trinidad and Tobago, Sir Solomon Hochoy who was accompanied by Mrs. Rose Miles, who was the wife of Mr. Hilton Miles who was at the time the person in charge of Alcoa operations in Trinidad that changed the lives of these children forever. Twenty-five (25) of the children were present at the time of the visit. Lady Hochoy and Mrs. Miles were so moved by
what they saw. They felt that the children should have a home of their own, and be removed from the adults. With this in mind, they approached appropriate people within the society and sought assistance.

A committee was appointed and in 1958 this led to the establishment of the Trinidad and Tobago Association for Retarded Children. This is the umbrella body under which the Lady Hochoy Home, the Memisa Centers and the Penal Day Care Center now fall. The first residential center of the Lady Hochoy was opened in Cocorite in March 20, 1961. This Home was constructed on lands donated by the Government and funded to the tune of two thirds by the Government. Before the establishment of this Home, mentally challenged children were housed with similarly afflicted adults in pitiful conditions. This Home served the entire country until centers in Gasparillo, Arima and Penal were established. The center has been serving children with intellectual disabilities in Trinidad and Tobago under the kind patronage of the Corpus Christi Carmelite Sisters for the last 45 years.

**POPULATION SERVED**

The Lady Hochoy Home serves both children and adults ranging from age 1 ½ to 59 years who suffer from intellectual retardation. The residential facility is home to 95 mentally disabled persons, 25 male and 70 females. The day school however serves between 125 and 135 persons on weekdays.

The Lady Hochoy home was established to serve persons with intellectual retardation. In 1992, the American Association on Mental Deficiency defined mental retardation as sub average intellectual functioning. It usually manifests itself in the developmental period, before age 18. Mental retardation normally limits two or more of the individuals adaptive skills; communication, independent self care, home living, social skills, community use, self direction, health and safety, functional academics and leisure and
work. These are skills a normal, mentally developed person takes for granted. Therefore mental retardation can affect the individual's intellectual as well as one's social, vocational and physical development.

Levels of Mental Retardation served at the Lady Hochoy home:

- **Mild Mental Retardation**

  This forms 90% of the mentally retarded. They may need assistance in complicated tasks but can achieve social, vocational and communication skills similar to their non-disabled peers.

- **Moderate Mental Retardation**

  This individual may show significant delays during preschool years. They can be taught basic academic skills and as adults can do well in simple repetitive tasks in a supportive environment.

- **Severe and Profound Mental Retardation**

  Identified at birth, these children may need 24 hour, round the clock nursing care but can be taught, depending on severity of retardation basic self-care skills.

- **Autism**

  Autism can often be identified from the first years of life. There is extreme isolation and an obsessive insistence on preservation of sameness. Also characteristic of autism is gaze aversion and speech abnormalities (echolalia). These individuals do not achieve good social adjustments.
THEORETICAL FRAMEWORK

After much careful consideration and based on data and information that were presented and gathered, there appears to be an overlapping of models and theories which guides the operation of the Lady Hochoy Home. Two theoretical frameworks, which are clearly emerging:

1. Medical model
2. The Systems theory.

Systems Theory

‘Eco-systems theory is a meta-theory that offers social work practitioners/clinicians a way of thinking about and assessing the relatedness of people and their impinging environments; it does not specify the what (problem-definition) or the how (methodology) of practice. For that it relies upon the increasingly large repertoire of available practice models, each one to make these specifications consistent with its particular theoretical orientations’ (Meyer, 1983: 29-30)

What does it offer?
Systems theory offers a way of conceptualizing the relationship between people and environments and encourages a balanced approach to both domains of practice. Emphasis is on the ‘goodness of fit’ between the client and their environment. Workers can focus on how family, community, social, economic and political factors affect the client’s situation.

The five principles of systems are:

1. All systems seek goal attainment and balance.
2. All systems have boundaries.
3. All systems are made up of subsystems.

4. The whole is greater than the sum of its parts.

5. All systems create feedback.

(Hoffman and Sallee, 1994)

The key assumptions of systems theories are that:

(i) individuals function as a part of many systems - they are affected by these systems and affect the systems
(ii) because systems are in dynamic interchange, a change in one part of the system will have consequences for other systems
(iii) problems arise because of a misfit between individuals and the systems of which they are a part
(iv) the role of the social worker is to enhance the fit between the individual and the systems affecting them

Principles of Systems Intervention

(i) the notion of partnership
(ii) the worker facilitates change but is not an expert about the system
(iii) sustained change
(iv) non-judgmental
(v) holism and recognition of social connection

How does it work?
The worker aims to enhance the fit between the individual and their environment. This is done by developing, maintaining or strengthening supportive interventions and reducing, challenging or replacing stressful systems.

**Stage 1: Systemic analysis**

- recognizing multiple systems
- recognizing multiple levels (micro, meso, macro)
- each of these systems is interacting with, and reliant on, each other

**Stage 2: Intervention**

Intervention should be targeted at the system(s) that will offer most potential and most leverage for change.

**Systems theory**

**Intervention focus:**

*Systems*

Change achieved through:

*Facilitating systems change*

Relationship between worker and client:

*Systems analyst and change agent*

Participation and partnership:

*Worker and client work together*

Measure of change:

*Enhanced integration of individual and systems*
Focus on broader political environment:

*Minimal*

Process of intervention:

*Multi-dimensional and open-ended*

Involvement of the broader community in change?

*Yes – enhancing individual and community ‘fit’*

Practitioners and Workers should:

- think strategically about the possibilities and limitations for change in the different systems affecting the client’s environment
- have an understanding of the possibilities for intervention in each system

The strengths and weaknesses of Systems Theory

**Strengths**

- focus on interactions between individuals and systems (doesn’t pathologies)
- fosters sustained change between individuals and their social environment
- can move beyond ‘presenting problem’ and delve into other more far-reaching problems and concerns
- recognizes the value of the social context, especially the contribution of formal and informal social systems

**Weaknesses**

- its underlying assumptions are questionable e.g. change in one part may not lead to change in another – can underestimate the resistance to change in a system
• can deny individual responsibility for change
• can support the status quo
• can bind workers and clients into long-term interactions with no beginning or end
• difficult to evaluate service effectiveness, because of the absence of ‘causes’ and ‘effects’

**MAJOR CRITIQUE**
- descriptive, not explanatory
- accepts systems as they are
- may disempower by taking away individual responsibility and agency

‘Almost without exception, the leading exponents of ecological-systems theory have given priority to the interdependence of person and environment, and have failed to explore the tension or dialectic between them’ (Kemp, Whittaker and Tracy (1997:44)

**'Medical Model' vs 'Social Model'**

**The 'Traditional Model'**

Traditionally, in many cultures around the world, people with physical, sensory or mental impairments were thought of as under the spell of witchcraft, possessed by demons, or as penitent sinners, being punished by God for wrong-doing by themselves or their parents.
The 'Medical Model'

With the Age of Enlightenment in the 18th century, came a more scientific understanding of the causes of impairment and, with it, a sense of confidence in medical science's ability to cure, or at least rehabilitate, disabled people. Some disabled people (often for social or political reasons) were deemed incurable and placed in long-stay institutions and special schools (or, today, in day-care centres). A notion of 'normality' was invested with great pseudo-scientific significance. It was based on assessments of impairments from a deficit point of view against normality: what one cannot do, instead of what one can do. This has been called 'medical model' (or 'individual model') thinking by the Disabled People's Movement over the last 30 years. This is not to deny the very necessary role of medical science in keeping many disabled people alive, and reducing their pain and discomfort, but it is to argue that disabled people should not be reduced to just their impairments.

The 'medical model' sees disabled people as the problem. They need to be adapted to fit into the world as it is. If this isn't possible, then they should be shut away in a specialised institution or isolated at home, where only their most basic needs are met. The emphasis is on dependence, backed up by the stereotypes of disability that bring out pity, fear and patronising attitudes. Usually, the impairment is focused on, rather than the needs of the person. The power to change disabled people seems to lie with the medical and associated professions, with their talk of cures, normalisation and science. Often, disabled people's lives are handed over to these professionals. Their decisions affect where disabled people go to school; what support they get; where they live; what benefits they are entitled to; whether they can work; and even, at times, whether they are born at all, or allowed to have children themselves.

In addition, the Disability Movement points out how the built environment imposes further limitations on disabled people. Medical model thinking would say these problems are due to the disabled person's lack of rehabilitation. The Disability Movement perceives the difficulties disabled people experience as the barriers that disable them and curtail their life chances. These difficulties include in school and higher education, in finding work and suitable work environments, accessing leisure and entertainment facilities,
using private and public transport, obtaining suitable housing, or in their personal, family and social life.

Diagram showing the effects of medical model thinking.

Powerful and pervasive medical model views are reinforced in the media, books, films, comics, art and language. Many disabled people internalise negative views of themselves and develop feelings of low self-esteem and underachievement, which reinforce non-disabled people's assessments of their worth. The medical model, plus the built environment and social attitudes it creates, lead to a cycle of dependency and exclusion which is difficult to break.

This thinking predominates in filmmaking, leisure, work and education. In schools, for instance, special educational needs are considered the problem of the individual, who is seen as different, faulty and needing to be assessed and made as 'normal' as possible.

Increasingly, today, the medical model is being rejected. Many people feel strongly that treating disabled people as needing to be adapted to existing circumstances or, if this is not possible, caring for them in specialised institutions, is wrong.

The 'Social Model'

In recent years, the disability movement has advocated a different way of looking at disability, which they call the 'social model'. This starts from the standpoint of all
disabled adults' and children's right to belong to and be valued in their local community. Using this model, you start by looking at the strengths of the person with the impairment and at the physical and social barriers that obstruct them, whether at school, college, home or work. The 'social model' defines 'impairment' and 'disability' as very different things:

"Impairment is the loss or limitation of physical, mental or sensory function on a long-term or permanent basis.

Disablement is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers." Disabled People's International 1981

Impairment and chronic illness exist and sometimes pose real difficulties. Supporters of the disability movement believe that the discrimination against disabled people is socially created and has little to do with their impairments, and that, regardless of the type or severity of their impairments, disabled people are subjected to a common oppression by the non-disabled world. Disabled people are often made to feel it's their own fault that they are different. If some part, or parts, of your body or mind are limited in their functioning, this is simply an impairment. It doesn't make you any less human. But most people have not been brought up to accept all people as they are; in other words, to value difference. Through fear, ignorance and prejudice, barriers and discrimination develop which disable some people. These are often reinforced by images in the media. Understanding this process allows disabled people to feel good about themselves and empowers them to fight for their human rights.
Diagram showing the problems as perceived by 'social model' thinking.

The 'social model' approach suggests disabled people's disadvantage is due to a complex form of institutional discrimination, as fundamental to society as sexism, racism or heterosexism. The disability movement believes the 'cure' to the problem of disability lies in changing society. Unlike medically-based cures, this is an achievable goal and benefits everyone.

The obsession with finding medically-based cures also distracts people from looking at the causes of impairment or disablement. In a worldwide sense, most impairments are created by wars, hunger, lack of clean water, exploitation of labour, lack of safety, and child abuse and these should be addressed more robustly, rather than just responding to the injuries and impairments that result from them.
Challenging prejudice

<table>
<thead>
<tr>
<th>Medical model thinking</th>
<th>Social model thinking</th>
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</thead>
<tbody>
<tr>
<td>Child is faulty</td>
<td>Child is valued</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Strengths and needs defined by self and others</td>
</tr>
<tr>
<td>Labelling</td>
<td>Identity barriers and develop solutions</td>
</tr>
<tr>
<td>Impairment becomes focus of attention</td>
<td>Outcome-based programme designed</td>
</tr>
<tr>
<td>Assessment, monitoring, programmes of therapy imposed</td>
<td>Resources are made available to ordinary services</td>
</tr>
<tr>
<td>Segregation and alternative services</td>
<td>Training for parents and professionals</td>
</tr>
<tr>
<td>Ordinary needs put on hold</td>
<td>Relationships nurtured</td>
</tr>
<tr>
<td>Re-entry if normal enough OR permanent exclusion</td>
<td>Diversity welcomed, child is included</td>
</tr>
<tr>
<td>Society remains unchanged</td>
<td>Society evolves</td>
</tr>
</tbody>
</table>

(Adapted from Michelle Mason 1994, R. Rieser 2000)

Chart comparing the attitudes of medical model and social model thinking.

Social model thinking has important implications for the education system, and particularly primary and secondary schools. Prejudiced attitudes toward disabled people and all minority groups are not innate. They are learned through contact with the prejudice and ignorance of others.

Therefore, it is appropriate that the challenge to discrimination against disabled people should begin in schools. The fight for the inclusion of all disabled people, however severe their impairments, in one mainstream social system, will not make sense unless people understand the difference between the social and medical models of disability.

The Social Model has now been adopted by the World Health Organisation.
**CRITIQUE**

1. No education programmes to inform, educate, sensitize and create awareness in the minds of the public of the plight and needs of the mentally challenged.
2. No resident physician to take care of the medical needs of the mentally challenged resident at this Home.
3. No psychiatrist or Social Worker resident or on a visiting arrangement on the staff of the Home.
4. Inadequate sporting facilities to meet the physical needs of the population.
5. No paramedics or ambulances are based at the Home.
6. Some of the staff is paid by the State; the others are paid from funds from voluntary donations from sympathetic members of the public.
7. Home depends too much on donations from the public and not sufficiently from Government subventions.

**RECOMMENDATIONS:**

1. Implement a paradigm shift from the medical model to the social model where the environment is adapted to fit the needs of the disabled and not the vice versa, notwithstanding the fact that medical model has some use as far as these disabled persons are concerned.

2. Use an eclectic approach to the social work practice. The systems approach is useful but should the psychosocial approach be added also, the strengths of one will supplement the weaknesses of the other and give a more ecological approach to the practice.

3. Add the following professionals to the staff so that the needs of the population can be more appropriately satisfied: -
   a. Social Worker
   b. Psychiatrist
   c. Medical doctor and support staff
d. Physical Education Instructor

e. Public Relations Officer, (to educate the public about disability in keeping with the motto)

4. Allow the children to have a greater interaction with disabled persons from other institutions

5. Implement a system where the population will have more interaction with the mainstream society

6. Carry the members of the institution on tours to places of interest like for example the botanic gardens, President’s grounds, Queens Park Savannah etc. so that they will be able to spend more time outside of the institution

7. A Speech Therapist should be included on the staff.

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