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## EDITORIAL

These are times when professional people have to re-orientate their attitudes and have to re-define their professional roles and contributions under pressure of new national policies. This applies particularly to disciplines working within the hospitals for the mentally handicapped which have been given quite clearly to understand that their traditional custodial functions will not be maintained in future and that the hospitals for the mentally handicapped will be smaller and will serve medical, rather than social needs. Whatever organisational changes will result from adopting a different emphasis and from redistributing responsibilities to other disciplines, these changes will not reduce the number of the mentally handicapped who need to be attended to, nor their particular handicaps, even though the nature of the concomitant problems may be considerably affected by new improved environmental conditions. Indeed, one would expect that the great effort of creating new environmental settings outside the large hospitals, the smaller living units, the involvement of non-medical and non-nursing disciplines will help in the development of the mentally handicapped himself, rather than merely provide better humanitarian storage arrangements for him. It has been widely appreciated that if we were to utilise fully our available resources and our knowledge, we would be able to prevent the spread of mental handicap and avoid making the situation worse than need be.

The present policies, which are dynamic in nature, look in the right direction and will, if wisely implemented, produce significant results in fifteen, twenty years. In the meantime we are faced with the practical complexities of a transition stage which can only too easily result in increasing the difficulties of the hospital subnormality services due to the disorientation caused by looking in two directions at once.

The hospitals have been accused—quite rightly—of being inward-looking and not being very much concerned with the problems in the community occurring outside the institution walls. The various disciplines in the subnormality hospitals—particularly the doctors, the nurses, the psychologists, specialised in dealing with the management problems presented by the mentally handicapped, should be, it is said, much more easily and widely accessible to people in the community who do not require or request hospital admission because this will often avoid or at least delay hospitalisation. To some extent this is already being done by outpatients clinics, assessment clinics, day hospitals, etc. Many a consultant, having seen the urgent needs in the community, has responded with alacrity and made himself available to urgent community needs.

Even better, the most forward-looking and enthusiastic doctors, nurses, psychologists and other specialists have responded to the exciting challenge by doing preventive sessional work outside the hospital setting—and yet, one must not forget,

the working day has only a limited number of hours. Every session spent outside the hospital on preventive community work is one session less available for the therapeutic remedial work with the hospital population. This is, of course, an old problem which every consultant had to settle with himself in the past. Nowadays, however, it has become more acute and pressing because of the multidisciplinary nature of our work. Nurses and psychologists, based in hospitals, have been dealing with the practical problems of individual non-hospitalised people and have designed and monitored treatment programmes to be carried out outside the hospitals. Some hospital specialists give advice and direct assistance to training centres, hostels and group-homes. These are time-consuming activities and it is seldom sufficient to attend to a problem only once or twice.

These are most welcome and promising developments which are exactly in the direction our efforts should head. But it is equally clear that community involvement deprives the hospital not only of the sessions by one consultant, but also of the work by other services required for the backing up and executing the preventive programme of action following the diagnosis and assessment. Three, four or more people, who are most likely the most active and experienced ones, will for certain periods not be available in the hospital to carry out their work there.

Hospitals for the mentally handicapped have, in recent years, been under heavy criticism for their inadequacies and for incidents which reflected adversely on their work. A good part of the critical comments referred to unsatisfactory management practices, which does not require extra financial resources or increased staffing. There is probably no hospital for the mentally handicapped in this country which can honestly say that all the loose ends have been picked up, that all the programmes are carried out as a matter of course, that all the daily practices relate correctly to the professed philosophy, that all objectives set at the beginning of a planned programme have been attained.

There is so much to be done in the institutions and hospitals if one wants to maintain a reliable and efficient service, which should not need the panic stimulation by official enquiries, royal commissions, hospital advisory service, group development teams. But it is also clear that the undoubtedly understaffed and underfinanced hospital subnormality service requires all its scarce resources to keep its own house in reasonable order to avoid its collapsing whilst one is busy helping the neighbours. After all, it must be remembered that the hospital institution has been awakened up from its long uneventful and unpromising custodial role by the advent of a host of new ideas, plans, programmes, therapies, all of which will have to be given a fair trial, necessitating very painful and much-resented adjustments and re-thinking of roles, contributions and organisation. The by now established multidisciplinary involvement in subnormality work, makes it imperative that people get constantly together—yet what a time-consuming process it has become sitting in on working parties, committees, meetings, and being busy with keeping the channels of communication open. Of course, all this has to be done, but how much additional commitment can be added on? And how welcome and effective will be a hospital team in the community, whose hospital base has not been able to improve on its poor reputation? And how good can be the backing up service of a hospital which is only considered as a last resource if everything else fails?

Let us face it, a subnormality hospital being a deprived section of the health service, cannot afford to lose the services of a team of good people without suffering some damage. Our resources are simply too limited and often not of such a high quality as not to feel it quite painfully, if outside commitments reduce within the hospital the high standard of achievements which can only be improved by full application of effort from all sides.

Of course, it is true that the long-term effects of any preventive work in the community will reap the benefits for the future. Of course, it is true that the parents and relatives, struggling with their unmanageable child, need all the help possible, and if the home care can be properly maintained a hospital or hostel bed has been saved. Of course, it is true that the doctors', nurses', psychologists' own expertise is increased to the benefit of everyone concerned, if they treat the problem of mental handicap in its own context, rather than in the isolation of the hospital. But, of course, it is also true that those professionals cannot rely on the effectiveness of treatment, training and education they prescribe for patients in the hospital unless they themselves can monitor the work and remove the obstacles interfering with it. There is no organisation and no administration which does not lose momentum if not constantly helped daily, revived and improved—and this is unfortunately dependent on those very people who will be asked to spend more and more time in the community once their therapeutic and preventive role there has been fully developed.

Are we then to turn a blind eye to the fact that we do not discharge fully our obligations to the people already in our care in hospital because we give them less than one hundred per cent attention? Are we quite sure that what has been done in the last few years in the way of physical improvements and increasing staffing, etc., is sufficient and no loose ends are left around? Are we confident that the people who are entirely in our care are given all that individual attention which we aim for in our community work? Are we quite happy about having used available resources so fully and competently that we can rest on our laurels and look for other, greener pastures?

Or are we perhaps escaping from a difficult and rather frustrating situation into the new and more promising work in the community—just as in the past the problems of the hospitalised mentally handicapped person were avoided by the doctor looking down the microscope, the psychologist studying the patterns of cognitive tests and the nurse making beds upstairs. Where do our priorities lie?