

POINT OF VIEW

The recent Department of Health and Social Security Review of the 1959 Mental Health Act (Appendix III) leaves to speculation the question as to whether or not the mentally handicapped should be included under the terms of any revised mental health legislation and within the confines of psychiatric medicine, indeed poses the question as to whether mental handicap can be seen as a medical condition at all. This must lead logically to opening the debate with greater ferocity as to the nature of the primary condition of mental handicap—is it educational, or social, or behavioural for example, and consequently, which Department or professional body will be seen as the most important, and therefore having the most power with regard to this minority group. Although there is merit in pursuing this question, particularly if the issues and implications mean a genuine better service for the mentally handicapped, there is danger yet again of precipitation and impetuosity resulting in confusion.

Most professionals who have taken a special interest in the mentally handicapped will be conscious of the barriers which have been erected between Health Service provisions (mainly hospitals) and services which exist in the community, albeit sparse. No one, I think, will dispute the fact that most of the expertise in working with this client group over the years has been with people with a Health Service background—be that Nurse, Doctor, Social Worker or Psychologist. No one again, will dispute that until comparatively recently no moves were made by the local authorities up and down the country to develop even the mere resemblance of a comprehensive service for the mentally handicapped, either living in the community or in hospital and fit for discharge. It is because I am convinced of the truth of the preceding statements that I must ask myself why it is that so much irresponsible decision-making has taken place over the past few years which has resulted in unsatisfactory social conditions becoming the common experience of so many mentally handicapped people. Was it because Richard Crossman played the tune and so many committed professionals danced? Or was it because hospital personnel wanted to teach indolent local authorities a lesson? Or was it that those who made the decisions did not and do not care? The tragedy for me is that, as a Social Worker who has worked in this field on both sides of the fence (and where the grass is equally green) we have, and have had, the power and resources to do a much better job.

Planning for better services has now gone on for many years, one of the latest attempts being the somewhat abortive Health Care Planning Team inaugurated by the District Health Authorities up and down the country. I had the misfortune, several years ago, of being selected to represent the Social Services Department who employed me at the time, on a sub-team planning service for the Mentally Handicapped. During the third or fourth meeting of the team I remember suggesting, because we recognise that mentally handicapped people have care needs and function at such a vast number of levels, that we introduce the concept of a "continuum of care" spanning the whole length of hospital and community-based services (this concept has recently been used by the National Development Group in its pamphlet, "Mental Handicap, Planning Together"). A medic on the team reminded me that we were a "Health Care" Planning Team and that we were primarily concerned with health services. I am sure that this sort of attitude would not have prevailed in all such teams, but had not the medical gentleman put his finger on the key which locks one of the important doors leading to a thoroughly genuine better service, i.e., preservation of a departmental or professional status quo? Some official recognition has been given to this in that we now have Joint Care Planning Teams. But the attitude can exist, even in the same Department like Social Services, where Day Support Staff will not be seen at the same cocktail parties as Residential Staff,

and both would like to eliminate Fieldwork Staff! What authority will harness all these divided forces each with so much power and resources for service? Furthermore, divisions make for serious gaps and I believe that the gaps are a primary cause of bad service.

Being currently involved in a special project in an area badly affected by the disorganised, unplanned, ill-managed discharge of hundreds of mentally disordered people from hospitals into an unprepared community over many years, I express the foregoing thoughts with a great deal of feeling. Since the object of the project is to assess the extent of the problem in this particular area and do something about it, feelings must be thrown to the wind and every ounce of energy exerted in favour of practical solutions. Let me say from the outset, that the community can cope and will cope if Departments and authorities aim together at a comprehensive service.

The first task of the Team of Senior Social Workers in the project was to monitor and control the flow of mentally handicapped clients into the ghetto areas which offered undesirable facilities. This led to an identification of the sources (community-based as well as hospital) from which clients more often come. Having arrived at that point, nothing further could be done (apart from a mere research-type fact-finding exercise) unless resources were established which would offer a comprehensive system of assessment, rehabilitation/training and support services which were community-based, in conjunction with the personnel of the identified sources already referred to. Most existing community resources are useless in the service of a large number of clients since they silt up soon after becoming operational. Because of the nature of the task in hand, therefore, it was seen that movement of clients within the system being established would be essential and that the operational programme of each larger unit in the system would be geared to this end. This movement through assessment and rehabilitation programmes would be meaningful, however, only if a series of resources were made available, one of which would suit the needs of an individual client, i.e., landladies, group homes, long-stay hostels, council flats. The system referred to consists of the following units:

1. **Pre-Discharge Day Unit.** A Social Services Department hostel in the community used during the day for assessment of hospital patients thought to be ready for discharge; hospital and Social Services staffs are involved together in this programme, which is completed for any one individual during the course of two weeks.
2. **Residential Assessment/Training Unit.** If a decision concerning the placement of an individual is not reached at the pre-discharge stage, a three-month stay in a residential unit is offered to make an in-depth assessment. Within a short travelling distance of the unit are the day training facilities of an Adult Training Centre and an Institute of Further Education.
3. **Long Term Rehabilitation Unit.** This is for the client whose needs were assessed as being long-term rehabilitation at the three-month residential assessment stage; the Unit will play a large part in guaranteeing movement through the system. At any stage in the process any client is free to drop out, or could be placed in one of the more independent living situations listed earlier.

The above is a very brief sketch of a method or practice, albeit a little mechanical. It concentrates on the client as the important person in the arena. A steering group has already been established to monitor the movement of clients through the early stages of the process, consisting of a Psychologist, Residential Social Worker, Psychiatric Community Nurse, Deputy Manager of an Adult Training Centre, Teacher in Further Education and a Senior Social Worker from the Specialist Team—all at practitioner level.

The majority of mentally handicapped people, in my experience, are able to make choices. A service will only become satisfactory when it offers a wide range of resources in terms of accommodation, occupation and leisure pursuits, so that whatever the mentally handicapped person gets, reflects something of his choice and meets most of his needs. To accomplish this aim is not as formidable as it first appears if we begin to scrutinise carefully which personnel are involved in planning the steps, and actually take the steps, towards the desired goals; in other words, by what authority is a service developed for the *mentally handicapped*. For me, the only future satisfactory, realistic service is one which is operated across departmental and professional boundaries and by those who have planned it. This does not dilute in any sense the individual nature of separate professions—confident co-operation gives professionalism more meaning. Perhaps in this way the mentally handicapped would reap the benefit of the greenest grass in all the fields.

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