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## EDITORIAL

The concept "Right to Treatment" is by now a widely accepted principle of progressive mental handicap work.

Treatment refers to any measure designed to help the mentally handicapped to function better by developing him. It should not be mistaken for that type of care which merely supports the mentally handicapped in best possible conditions on his existing level of functioning. 'Treatment' means a deliberate attempt to change a person for the better, 'care' means an attempt to perpetuate a good situation — and both concepts are justified in the work with the mentally handicapped.

The care aspect has a long and not always distinguished historical record — and the sins which have been committed at times, when the colony, the institution etc., was 'out of sight, out of mind' are too well known to need further elaboration. Strenuous efforts are made nowadays to provide better forms of care in materially vastly improved facilities, and by organisational breakaways from the past. These are steps in the right direction. Treatment in the hospitals for the mentally handicapped should consist, despite its medical/nursing over tones, mainly of developing the residents' social and personal functioning by applying suitable ways of systematic teaching and behaviour shaping. The medical contribution can help to make people accessible to developmental endeavours, but the emphasis of the treatment must be on helping the mentally handicapped to adjust to society and to improve his self-reliance.

Once it has become quite clear that the mentally handicapped person's right to treatment refers not only to medication where necessary, but also to active help in reducing his social and personal handicaps, one has to look more carefully at the implications this has on management issues and particularly whether the 'dynamic' change inherent in the treatment concept could lead to conflict with the often unconsciously prevailing essentially static care concept.

Providing education and training within the framework of hospitals, institutions or day facilities such as adult training centres presents usually no major problems — only technical and financial difficulties. We have seen remarkable changes for the better during the 'last few years'. But the very fact that the 'technical' improvements have been so impressive, might induce us to overlook that 'treatment' consists not only of teaching social and domestic skills but, as already stated, of helping mentally handicapped persons live with others, to make decisions and to rely to some extent on themselves.

This so necessary adjustment to society and self reliance can, however, not be learned as 'subjects' included in the educational syllabus. They represent areas which are vitally important for influencing the immaturity, instability, insecurity of mentally handicapped people. No doubt, skills taught in schools, in the workshops, in further education, in evening classes will help the mentally handicapped in some ways to become more familiar with the demands of life, of society. It is part of treatment because competence in these areas strengthens positively their position in the community and their attitudes towards others. Yet, unless they are also helped in learning the use and application of these skills in situations of increasing complexity and decreasing support, we have failed to give more than symptomatic treatment.

In practice our mental handicap services are essentially protective care services, instead of developmental treatment services because they limit themselves to teaching 'domestic, social skills' of various types. They do not dare to take those risks which are part of the weaning process when the dependence in the care situation is to be changed to independence in one or the other form of community living. Even if the protective supervision is less obtrusive than at present, there is a stage in the weaning process where people should not be able to rely on the immediate support and presence of staff, where it is necessary for the mentally handicapped to apply what he has been taught without being able to turn to other people for confirmation and reassurance. This is a time of risk but it cannot be avoided. Knowing full well that the mentally handicapped person is more at risk than any other 'normal' member of the community, few people in responsible positions dare to take the decisions of introducing general programmes which aim at decreasing protection gradually and exposing the mentally handicapped thereby to risks. We know, even though there are individual exceptions where the personality of the mentally handicapped person is judged to be suitable to exposure to risks, there are many more mentally handicapped people who cannot be helped along because no one dares to take the risk and because the system as such does not permit it.

In the hospital ward the protective care attitude will insist on a twenty-four hour supervision, on pre-mixed water instead of hot and cold water, on direct supervision of bathing, on discouraging independent actions such as making appointments at the optician etc. All these may be justified measures in the majority of cases but they are quite unjustified for the minority who need to learn how to rely on themselves. Does this mean that the institution can never take an active part in the development of independence, or personality, because the protective concept of hospital care contradicts the risk taking concept of treatment?

How far are the programmes of day facilities — the ATCs — geared to developing independence, to furthering personality, to teaching decision making, to adjusting to the needs of individuals?

Once again there is a danger that splendid workshop arrangements, domestic training facilities, participation in further education etc., all of which are proud and significant achievements will make us overlook the essential aim which is to help the person to decrease his personal handicap and not only to train the mentally handicapped to become a better worker and to handle money or to use the bus.

Services are often regarded as 'good' and progressive, if they provide impressive factory machinery, if the timetable shows periods for reading and writing, for cooking of snacks and of three course meals, for going shopping etc. Indeed, teaching of these "knowhows" is important but their effectiveness for the mentally handicapped will depend on the number and variety of opportunities in which they can be applied and which will have to be different for persons of different ability. It follows, therefore, that the essence of good service is flexibility in approach and managing individual situations. Timetables, programmes, staff deployment must be able of adjustment to guarantee for each person that degree of independence which he can just manage and which can lead to a more challenging situation later on where we are uncertain whether he can manage it.

Adjusting to the needs of a person who is to learn how to cope with relative independence, requires also the acceptance by the professional of the heavy burden of taking considered risks. Who is to take the responsibility? Is it the staff immediately concerned or is it the appropriate authority? The trend encountered nowadays is a protective trend. Protection against possible injury, protection against possible fire, protection against possible accidents, protection against possible accusation of exploitation, protection against charges of neglect of duties and so on. This is the first reaction to any proposal to giving the mentally handicapped a higher degree of independence, even if it is only concerned with turning on the bathwater or eating with knife and fork. It is a protective attitude common to parents, staff and authorities and is upheld by standing orders, regulations, guidelines etc.

*Mentally handicapped people sit nowadays in better furnished accommodation, are involved in industrial work, obtain wage packets and are given opportunities for shopping, but these achievements often camouflage the facts of continued overprotection and dependence on support, though there are many mentally handicapped people who could go further than we permit them to go. There is no doubt that the right for individualised treatment suffers considerably in the cases of a minority, who must be subjected to the practices found useful in the management of the majority of less capable people. We must somehow learn to accommodate within our present provisions, areas of independence, where some mentally handicapped people can try to live by themselves and no one will be accused of neglecting his duties if "accidents" were to occur. Adequate, intensive preparation for such a stage is essential, but there must be a time when the supportive hand on the shoulder is no longer constantly in evidence.*

There is a very real danger that the generalisation: 'the' mentally handicapped produces a generalised approach of care and protection. This overlooks the fact that the individual must be stretched by demands on him — not merely by training and education — and that this stretching is an essential aspect of his personal development. Of course, like any other human being, he may not measure up to expectations and be injured — which is an occupational hazard — or, he may vastly exceed our expectations — which is a highly welcomed gain but is only achieved by both parties — the mentally handicapped and his helper — having taken the considered risks inherent in 'learning to live.'