Point of View

THE INTELLECTUAL TWILIGHTERS

'Twilight' refers to that nebulous area between dark and light and this seems an appropriate metaphor to describe that group of people that falls intellectually between those who are normal and those who are clearly severely subnormal. We are talking about that group with an IQ broadly in the 55-80 range, those who - in educational terms - are now referred to as the ESN(M). This group has, I believe, needs of its own and cannot necessarily be seen as part of a homogeneous subnormal group. What is also significant is that the severely subnormal - though obviously constituting a major problem - are statistically very much in the minority. Jackson (1977) points out that, for every severely mentally retarded person in Britain, nine are mildly retarded and, in relation to the general school population, Parkin (1975) mentions that there are as many as 1% of the total school population in ESN(M) schools.

This is the present situation but it is obviously not static. Indeed, the indications - such as admissions to ESN(S) schools - are that the incidence of severe subnormality is diminishing significantly. This is very much a result of improved medical (especially pre-natal) facilities and greater public awareness and 'take-up' of these facilities. But Clarke (1980) has show how this change is not taking place in the higher 'subcultural' range of intelligence where other than physical/medical factors are largely contributing to the condition. It is also worth mentioning that this group of mildly mentally handicapped exists not only in all Western societies with their increasing stresses but Jackson shows evidence that similar phenomena exists in other cultures, such as East African tribes.

I will refer in more depth to the problem as related to adolescents of this intellectual range - though problems obviously do not disappear necessarily as people move into adulthood (Clarke mentions that there is, in fact, some 'self-curing' process with this group as they get older - with many, there is indeed slow learning and maturation). There is, I think, in comparative terms, a fair amount of resources allocated to both the 'problem' child of *normal* intelligence and those of the *below IQ50* level of intelligence. For the first group, we see foster schemes, family group homes, adolescent units, community schools and intermediate treatment, and much of this has developed since the 1969 Children and Young Persons' Act and the 1975 Children Act. For the second group, there have been obvious changes since the 1959 Mental Health Act and the 1971 White Paper 'Better Services for the Mentally Handicapped'. We have seen some movement out of long stay hospitals, less long term admissions to such hospitals, and concurrently the gradual development of community resources such as hostels, adult training centres, greater social work/domiciliary nurse support and even community-based special care units. No-one would pretend that these facilities are adequate - but *comparatively* these groups are clearly better served than the ESN(M).

What sort of specific problems do this group have? Very many individuals look quite normal- yet cannot fit in to normal groups. Because they look normal, unrealistic expectations are placed on them by society and often well-meaning parents. They suffer from low self esteem and lack of confidence because of consistently poor achievement and social adjustment, relative to peers and siblings, Yet, though it is wrong to treat them as normal, it is equally wrong to treat them *as* retarded - which is the other extreme to which both parents and society will go. Lee (1977) looked at a group of this

type in America and concluded that it is "wrong to view them as fragile, in need of protection, with inability to verbalise, not able to interact". These young people cannot cope with ordinary youth clubs - yet are insulted by and equally out of place in the many clubs in the community for the severely subnormal (the same applies to hostels for the mentally handicapped). So somehow we have to find a subtle 'midway' approach. Many of these adolescents have low levels of frustration tolerance heightened by their inability to understand many everyday things - and this often results in referral to the authorities because of anti-social behaviour at this crucial stage of their lives.

Where would we look for better provision? By definition, it is clear that the needs of the ESN(M) are recognised by the education authorities and everywhere there are both ESN(M) and ESN(S) schools. One can argue for and against segregating the ESN(M) from their normal peers and obviously there is no ready solution. Parkin feels that it may be advantageous for this group to start to re-join their normal peers nearer school leaving age. There is some post-school provision with work preparation courses and, in colleges, further education and adult literacy courses. But there is little available in the area of orthodox employment. A recent report (Manpower Services Commission Working Group 1979) showed that there is little sympathy generally by employers towards this group; where they did offer any employment, it was mainly 'unskilled' with the assumption that these youngsters could not benefit from training. There are also few appropriate social outlets for these people. At a developmental stage when young people are wanting to increase independence from home and maximise peer group contact, these youngsters are often isolated on housing estates, no friends, no stimulation - and this must especially be apparent to them at that crucial stage of leaving school. This is a clear recipe for anti-social behaviour, either within the home against those closest to them or against society, by breaking the law - and gaining some measure of frustration-relief, achievement, or just recognition of their existence!

If these specific needs and problems attributable to this group could be dealt with at an appropriate stage, then many of the crises we in the caring professions experience later with them may be avoided. Admittedly, there are other intra-family problems arising out of the 'handicap' which cause breakdown and crises, irrespective of other needs and provisions referred to - but I believe the majority of referred problems could be avoided by adequate employment and social facilities.

Fraser House, at Prudhoe in Northumberland, a hospital-based short stay unit for a maximum of eighteen ESN(M) disturbed adolescents, was established in 1975 specifically to help these youngsters and their families through the crisis and aid them in re-adjustment to the community. One could argue against the value of moving people into hospital when the prevailing climate is in the opposite direction! But the stay is never longer than 1 year with frequent ongoing contact retained with home and the community generally - and, at the present time, there is probably still greater professional expertise in hospitals. Also, it has been recognised that hospitals will continue to offer specialist help of this type; the Development Team for the Mentally Handicapped (1978), for example, described the need for "a unit for children and adults with behaviour problems that cannot be dealt with by community services". With a management team of psychiatrists, nursing staff, social worker, teacher and psychologist, the treatment at Fraser House is based on mixed community living, group work, socialisation, self-help skill learning, education (where appropriate) and vocational/work experience. The Unit is mixed and encourages youngsters to learn how to relate in a socially acceptable way to members of the opposite sex.

In a survey of the 32 admissions to the Unit in a period between March 1977 - March 1979, the following details will give some clearer indication of our intake and results.

a. **Total admissions:-** 32 (16 each year). Boys: 19. Girls: 13.

b. **Age on admission:-** The majority (23) were in the 14-17 age range.

c. **Length of stay:-** Mean: 6.3 months. Median: 5.5 months.

d. **Referral agency:-** 27 were referred either by consultatants or social service departments or jointly. 5 were referred directly by assessment centres.

e. **Referral problems:-** Sometimes there was a combination of behavioural problems but 13/32 were mainly management problems at home, 8 were management problems in another residential establishment, and 5 were for delinquency.

f. **Referral areas:-** We had referrals from 11 local authorities areas in that period - up to 100 miles distant - which demonstrates the general paucity of similar facilities.

g. **Range of Intelligence:-** A crude indicator of functioning but 24 were in the IQ50-80 range, the others slightly above or below.

h. **Outcome:-** This has not been assessed in any really objective way and I can only give a 'crude' opinion based on consultation with a cross-section of colleagues and some relatively objective data (such as, for example, increased socialisation, self-help, confidence, achievement in school work, etc.).

I looked at 1. progress within the Unit during stay
and also 2. the extent to which this was maintained a year after discharge.

The latter is really the 'raison d'être' for the Unit and while there is clearly fair-to-good progress within the Unit with 19/27 subjects (N.B. Five withdrew for varying reasons before treatment was considered complete), this was *not* really maintained significantly on discharge. What feedback I have been able to obtain (on only 24 subjects) suggests that at least 11 were not coping satisfactorily in the community to the extent of either continuing to present management problems at home or perhaps in again breaking the law. Obviously, this might point to some fault in our treatment methods, though this would be very difficult to analyse. However, we have already drawn attention to the lack of suitable facilities in the community and this is the reality to which our youngsters must inevitably return and often to very much the same situation from which they were referred.

This figures will hopefully give readers some idea of our aims, methods, and results, and Fraser House is certainly not intended to be a panacea for all 'ills' for such adolescents, only an example of the type of help that *might* be offered to a group for whom there is otherwise very little.

What changes and improvements should we then be hoping for? Comparatively, the educational provision as it stands does seem appropriate, though there is maybe a need for greater preparation for the world beyond school leaving age. There is a clear need for better education of potential employers. In the social sphere, we should be looking both for more social/youth clubs and intermediate treatment-type facilities specifically for this group - as well as more appropriate longer term residential provision (e.g. specifically-geared family group homes and hostels). The Warnock Report (1978) does provide some encouragement, though its focus was mainly on educational needs and on handicapped children in general. It felt that there should be

opportunity for many more handicapped people to attend Further Education and Training Service Agency vocational courses; it recommended also more discourse between local education authorities, careers services, and employers and employers' organisations, and more flexibility in the public sector especially.

The major and primary need, though, is for more actual *recognition* and *awareness* of the needs and even existence of this group as distinct - and from this would hopefully come a more sensitive, less unitary approach. This recognition and awareness needs to start in the caring professions as we are surely in the best position both to help parents and to influence others such as employers, statutory bodies and ultimately government. Only then can these young people hope to emerge from their present 'twilight' world.

Prudhoe Hospital,
Northumberland.

DEREK E. HOOPER,
Senior Social Worker.

References.

Clarke, A. D. B. (1980). Prevention and Amelioration in Mental Handicap. *An address to the Newcastle Branch of the Association of Child Psychology and Child Psychiatry.*

Jackson, R. (1977). Mild Mental Retardation: Myth or Reality? *Brit. J. Mental Sub.*, 23, 45, 76-82.

Lee, J. A. (1977). Group work with mentally retarded foster adolescents. *Social Casework*, (March).

Parkin, L. (1975). The Education of the ESN(M) Child. *Aspects of Education*, No. 20 (July).

National Development Team for the Mentally Handicapped (1978). 1st Report, 1976-7. HMSO.

Report of the Committee of Enquiry into the Educational Needs of the Handicapped Child and Young Person (Warnock) (1978). Special Educational Needs. HMSO. CMND 7212.

Report of the Working Group convened by the Special Programmes Division of the Manpower Services Commission (1979). Special Programmes, Special Needs. New Opportunity Press.