

# SYMPOSIUM ON CHANGES OF ENVIRONMENT: PERSONAL AND SOCIAL CONSEQUENCES

## I. CLOSURE OF AN OLD MENTAL HANDICAP HOSPITAL AND THE SHORT-TERM AND LONG-TERM EFFECTS ON RESIDENTS

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### INTRODUCTION

An important aspect of the movement towards community care for the mentally handicapped is the transfer of residents in hospital to community residential care (Command 4683, 1971). As the numbers in hospitals fall, closures of some old hospitals are expected. These concepts have been central features of the Sheffield Development Project for the Mentally Handicapped (Feasibility Report MO (MS) 46, 1971). Between 1975 and 1980, 5 old (albeit fairly small in relative terms) hospital units in Sheffield housing about 400-450 residents between them were closed and a further unit with about 70 residents is to close in September, 1982. Residents have been moved to a variety of new provisions ranging from new purpose-built hospital facilities, Health Authority and Local Authority hostels to unstaffed group homes. This paper looks into the details and effects of the first of these closures with particular reference to the residents involved and the lessons which can be learned from the exercise.

Immediately preceding its closure, Hollow Meadows Hospital was an *all male* unit for mentally handicapped adults with 83 permanent residents. It was situated 4 miles west of the outskirts of Sheffield in an exposed and isolated position, 1200 feet above sea level. The accommodation was old and inconvenient. The first group of residents moved out in November, 1976 and the hospital finally closed in January, 1977. The building was eventually sold in 1980 to a consortium of businessmen but still remains unused.

### METHOD

The Sheffield Case Register (Martindale, 1976), as part of its routine work, has collected details of the services received by ex-Hollow Meadows' residents since the hospitals closure. As a special project, frequency of contact with relatives, education, training and employment and social and physical incapacities (SPI), speech, self-help and literacy (SSL) skills (Kushlick *et. al.*, 1973) of each client were assessed just before the hospital closed. They were assessed again shortly after the closure of the old hospital (in autumn, 1977) and finally 3 years later in autumn, 1980. In this way, the problems exhibited by the residents were studied so as to evaluate the short and long-term 'progress' made by the residents in relation to the services they received over a 4 year period. However, it is *not* the purpose of the paper to compare the effectiveness of different types of units in helping residents to develop since no control groups were available and because different types of units accepted residents with different levels of dependency.

From the later information, judgements were made as to whether there had been no change, deterioration or improvement since the previous assessment(s). In the case of employment and education, judgements were made as to whether each person was receiving more or less. (In some cases, increasing employment automatically meant less education and vice-versa).

All the follow-up interview assessments were carried out by one interviewer (one of

the authors of this paper—C.A.K.) but the original assessments were split between two other interviewers. We have no reason to believe that this has had any effect on the findings since all three interviewers receive(d) standardised and specific training.

## RESULTS

Table 1 shows the initial placements of the 83 residents following the closure together with their eventual placements in autumn, 1980.

**TABLE 1**  
Schematic representation of transfers of clients, autumn 1976—autumn 1980

PRIOR TO CLOSURE AUTUMN, 1976		Hollow Meadows Hospital (83 Male Residents)						
		Old hospitals	New hospitals	New hospital hostels	Old hospital hostel	Part III <sup>2</sup> homes	Home	Died
PLACEMENT OF RESIDENTS AFTER CLOSURE OF HOLLOW MEADOWS— AUTUMN, 1977		21	35	19	1	1	2	4
	Old hospitals	11	3	2	—	—	—	—
	New hospitals	5	18	1	—	—	—	—
PLACEMENT OF RESIDENTS— AUTUMN, 1980	New hospital hostels	1	7	13	—	—	—	—
	Old hospital hostels	—	—	—	1	—	—	—
	L.A. hostels <sup>1</sup>	1	1	1	—	—	—	—
	Part III homes <sup>2</sup>	—	1	—	—	1	—	—
	Home	—	3	1	—	—	2	—
	Died	3	2	1	—	—	—	4

<sup>1</sup> L.A. hostels are small residential units for the mentally handicapped, which are managed by the Local Authorities (L.A.)

<sup>2</sup> Part III homes/accommodation are small residential homes for the elderly, which are managed by the Local Authorities (L.A.)

It must be noted in considering Table 1 that, between 1977 and 1980, some residents transferred between units of the *same type* and some moved *more than once* between different types of units. These moves are not shown in the table but the end result was that only 31 of the original residents remained in the unit to which they were originally transferred during the period 1977-1980. A fuller discussion of the effects of and the reasons for multiple transfers is given later in the paper.

There were 73 of the 83 ex-Hollow Meadows' residents still alive in autumn 1980 of whom 6 had returned eventually to live at home. Data was available on all three dates for 62 of the remaining 67. This paper concentrates upon those 61 residents in old or new hospitals or new hospital hostels. Numbers of those transferred to other types of unit were too small to consider.

## Age

The generally aging sample of residents is reflected in the fact that 10 of the 83 had died in the four years since the closure. Of those remaining, the modal 10-year age-group was 55-64 years. Age was not a primary placement factor but nevertheless only 2 of the 24 residents under 45 years of age in the survey were eventually placed in old hospital units. Although 14 residents over 45 years of age were eventually transferred to old hospital units, another 23 were housed in new units and 2 were finally transferred to Part III homes. The effect of these age considerations on the other aspects of the comparisons are discussed later in the paper.

## Education, training and employment

Just before Hollow Meadows Hospital closed, 10 residents were employed within the hospital or hospital gardens, 1 was in outside employment and 8 attended A.T.Cs.<sup>1</sup> Thirteen were attending adult education classes in the evenings but some of these were in the above groups.

The most obvious short-term effect of the transfers of all the different types was to give more residents education (or training) and employment opportunities. These net short-term effects in autumn, 1977 are shown in Table 2 together with the equivalent long-term effects.

TABLE 2  
Short-term changes in education (including training) and employment of residents,  
autumn, 1977 (long-term changes shown in brackets)

TYPE OF UNIT TO WHICH TRANSFERRED	EDUCATION/EMPLOYMENT	CHANGE:				
		MORE	LESS	NONE	NK	TOTAL
Old hospitals	Education	6( 3)	1(—)	11( 9)	3(4)	21(16)
	Employment	3( 5)	4( 1)	12( 8)	2(2)	21(16)
New hospitals	Education	18(10)	4( 3)	9( 9)	4(2)	35(24)
	Employment	9( 9)	4( 5)	19( 8)	3( 2)	35(24)
New hospital hostel	Education	11( 9)	2(—)	4(11)	2(1)	19(21)
	Employment	5( 5)	1( 5)	11(10)	2(1)	19(21)
All units	Education	35(22)	7( 3)	24(29)	9(7)	75(61)
	Employment	17(19)	9(11)	42(26)	7(5)	75(61)

Whilst the short-term effect was primarily to increase education/training, more residents than not were also more gainfully employed (*e.g.* helping in the units to which they were transferred) except in the case of those transferred to other old hospitals as perhaps may have been expected. A minority of residents were adversely affected by the initial transfers. This is explained by the circumstances of these individual residents some of whom were no longer able to 'work' in the gardens or on contract work or who ceased to attend evening classes, for example, when transferred to a hostel. Such 'adverse' effects may therefore have been counterbalanced by other benefits. However, a sizeable proportion of the groups were neither given more nor less education, training or employment on transfer particularly if they were transferred to other old units in the city.

Between 1977 and 1980, the situation changed somewhat—partially as a result of further transfers and partially as a result of policy changes. Some residents began to attend A.T.Cs. perhaps as a result of moving to hostels but to offset this some ceased

<sup>1</sup> A.T.Cs. (Adult Training Centres) are non-residential training centres for mentally handicapped adults which are managed by the Local Authorities (L.A.)

to attend (and maybe moved back from hostels to hospital units). In the new hospital units, some of the older residents ceased to attend day centres staffed by teachers within those units (and in some cases moved to old hospitals) so as to give younger residents (moving in from other units) increased attention. By comparison with the short-term effects one can conclude that overall, whilst fewer residents benefited from improved education in the long-term than in the short-term, fewer were adversely affected also and the long-term net effect was beneficial. In the case of employment, the long- and short-term effects were similar with a slight net beneficial effect particularly as a result of increased help being given by residents within hospital units in domestic living activities.

#### Contact with relatives

Prior to the closure, about one quarter of the residents were visited by relatives weekly and a further quarter had had some contact with relatives in the previous three months. Following transfers, the frequency of contact with relatives changed for some individuals either because it became more or less convenient to visit or for some other reason. Six residents, 2 immediately and 4 at a later date, returned to live at home—8% of the initial sample. For those alive and remaining in residential care the net short and long-term effects are given in Table 3.

TABLE 3  
Short- and long-term effects on contact with relatives

TYPE OF UNIT	SHORT/LONG-TERM	VISITING:				TOTAL
		MORE FREQUENT	LESS FREQUENT	NO CHANGE	NOT KNOWN	
Old hospitals	Short-term	4	4	11	2	21
	Long-term	4	2	8	2	16
New hospitals	Short-term	3	6	23	3	35
	Long-term	2	2	18	2	24
New hospital hostels	Short-term	5	3	9	2	19
	Long-term	5	5	10	1	21
Total	Short-term	12	13	43	7	75
	Long-term	11	9	36	5	61

Table 3 shows that the net effect on contact with relatives of closing Hollow Meadows was fairly neutral in both the long- and short-term for all kinds of transfers, but the figures mask quite interesting 'stories' behind some events which are unfortunately too lengthy to relate in a paper such as this.

#### Management problems posed by residents

Just before the closure, about one third of the residents had severe behaviour or incontinence problems and a further 17% had mild behaviour or incontinence problems. Of the half remaining a few had some degree of epilepsy and some needed help with feeding, washing and dressing. Nevertheless, there were about a third of all the residents with no such difficulties. By comparison with the general population of mentally handicapped people living in hospital units in Sheffield at that time (see Martindale, 1976b) the group at Hollow Meadows were fairly typical except that they were *all men* and *did not include any with severe mobility problems*. Because, the original group were not seen as having *mobility* problems, it is not surprising that no improvements in mobility were identified in the short- or long-term for any type of transfer. However some increasing mobility problems were identified in the long term;

4 amongst the 16 residents eventually transferred to old hospitals, 5 amongst the 24 residents eventually transferred to new hospitals and 2 amongst the 21 transferred to new hospital hostels. In nearly all cases, these came about through physical deterioration accompanying aging in the individuals concerned.

Turning to *behaviour* problems, it was in this area that the most changes in residents occurred both in the short- and long-term and these are summarised in Table 4 below.

TABLE 4  
Changes in behaviour problems of residents

TYPE OF UNIT	SHORT/LONG-TERM	BEHAVIOUR:				TOTAL
		IMPROVED	DETERIORATED	NO CHANGE	NOT KNOWN	
Old hospital	Short-term	8	10	1	2	21
	Long-term	6	6	2	2	16
New hospital	Short-term	13	17	4	1	35
	Long-term	9	9	6	—	24
New hospital hostels	Short-term	8	4	5	2	19
	Long-term	7	7	6	1	21
Total	Short-term	29	31	10	5	75
	Long-term	22	22	14	3	61

Very few residents did not show either improvement or deterioration in either the short- or long-term or both. In the short-term, deteriorations outnumbered improvements in old and new hospitals but the reverse was the case for the new hospital hostels. In the long-term, improvements and deteriorations overall exactly cancelled one another out. Amongst those (30) experiencing multiple transfers since the closure there were more (7) deteriorations since the first reassessment than improvements (2). Those who had remained in the unit to which they were transferred originally (31) had exhibited 7 improvements since the first reassessment and only 2 further deteriorations. This suggests that multiple transfers may have caused some deteriorations in behaviour but the numbers are too small to test statistically. Moreover, it is known from staff who were interviewed to collect the data that some multiple transfers were made because the residents behaviour deteriorated after their initial transfers. Nevertheless, overall the long-term effects were less pronounced than the short-term effects. This was true for the three types of transfer under consideration, the majority of behaviour changes having occurred in the period between the closure and the first reassessment. In connection with these changes in behaviour problems we also rated the *social interaction* of residents at each assessment on a scale ranging from 1 (makes friends and communicates with others) to 7 (irresponsive). Whilst this scale is neither standardised nor validated, the results throw light upon the changes in behaviour described above. In the short-term, social interaction decreased in more cases than it improved for each type of transfer with a total of 25 decreases and only 8 improvements amongst all the 75 residents. By contrast, in the long-term there were only 6 decreases and 9 improvements amongst all the 61 residents, most having apparently recovered former levels of interaction once again and even exceeding former levels in some cases. In this data about relationships therefore, there is apparently clear evidence of a short-term adverse effect eventually being overcome even though about half of the residents concerned were transferred again.

Turning now to problems of *incontinence*, 14 residents posed severe problems and a further one had mild incontinence prior to the closure. In the short- and long-term both

improvements and deteriorations occurred in all units but numbers were generally greater in the short-term as shown in Table 5 below.

**TABLE 5**  
Changes in problems of incontinence

TYPE OF UNIT	SHORT/LONG-TERM	INCONTINENCE:				TOTAL
		IMPROVED	DETERIORATED	NO CHANGE	NOT KNOWN	
Old hospital	Short-term	5	5	9	2	21
	Long-term	3	1	10	2	16
New hospital	Short-term	5	10	19	1	35
	Long-term	3	2	18	1	24
New hospital hostels	Short-term	5	—	12	2	19
	Long-term	4	2	14	1	21
Total	Short-term	15	15	40	5	75
	Long-term	10	5	42	4	61

In the short-term, apparent deteriorations exceeded improvements amongst those transferred to new hospitals but were matched by an equal number of improvements amongst those transferred to old hospitals and were exceeded by improvements amongst those transferred to new hospitals. In the long-term, some improvements were not maintained. However, most deteriorations appeared to have been recovered in old and new hospitals resulting in a net overall long-term improvement being apparently achieved.

Looking finally now at *self-help problems* exhibited by the residents (i.e. problems with feeding, washing and dressing), 28 of the original 83 residents had problems in at least one of these areas. Again, in both the short- and long-term, improvements and deteriorations were found as summarised in Table 6. Changes amongst residents in new hospital hostels were so few in both the short- and long-term that details are not shown in Table 6: In the short-term there were no changes in feeding, 2 in washing and 2 in dressing among the 19 transferred to new hospital hostels and in the long-term the equivalent figures were 1, 3 and none respectively.

**TABLE 6**  
Changes in self-help problems amongst residents

SKILL	HOSPITAL	SHORT/ LONG-TERM	HELP NEEDED:				TOTAL
			MORE	LESS	NO CHANGE	NOT KNOWN	
Feeding	Old	Short-term	2	2	15	2	21
		Long-term	3	—	11	2	16
	New	Short-term	6	1	27	1	35
		Long-term	9	2	13	—	24
Washing	Old	Short-term	8	1	10	2	21
		Long-term	4	2	8	2	16
	New	Short-term	8	10	16	1	35
		Long-term	7	6	11	—	24
Dressing	Old	Short-term	5	6	8	2	21
		Long-term	2	6	8	2	21
	New	Short-term	3	6	25	1	35
		Long-term	4	5	14	1	24

In the short-term, amongst those transferred to old hospitals, increasing numbers seemed to need more help with washing than appeared to be the case originally but increases and decreases in feeding and dressing skills seemed to counterbalance one another; amongst those transferred to new hospitals, increasing numbers needed more help with feeding than before the transfers but fewer needed more help with washing and dressing. In the long-term, the pattern was quite different. The numbers apparently requiring more help with feeding in both old and new hospitals had increased and totally outnumbered those requiring less help; improvements and deteriorations in washing and dressing skills tending to cancel out one another for both types of transfer. This is a confusing picture and one which is explained in the discussion section.

### Speech and literacy skills

Twenty of the original 83 residents were unable to speak in sentences. Changes following the closure are shown in Table 7 below.

TABLE 7  
Speech changes amongst residents

TYPE OF UNIT	SHORT/LONG-TERM	SPEECH:				TOTAL
		MORE	LESS	NO CHANGE	NOT KNOWN	
Old hospitals	Short-term	1	8	10	2	21
	Long-term	2	3	9	2	16
New hospitals	Short-term	3	4	25	3	35
	Long-term	4	5	13	2	24
New hospital hostels	Short-term	—	2	15	2	19
	Long-term	3	3	14	1	21
Total	Short-term	4	14	50	7	75
	Long-term	9	11	36	5	61

Initially, the productive speech of those transferred to old hospitals declined but improvements and deteriorations amongst those transferred to other units were very small. In the long-term improvements and deteriorations virtually matched one another.

Moving on finally to consider *literacy* about half of the original sample were considered to have no literacy skills prior to leaving Hollow Meadows. In the assessments shortly after the transfers, many more residents in all types of unit were considered to have even lower levels of skill than was originally thought. Since it was unlikely that residents had actually lost these skills in such a short time, it is believed that the original assessments were unreliable and because of it, short-term and long-term changes are not compared. Instead, the progress between the first reassessment in 1977 and the second in 1980 is studied. For all categories of placement, apparent improvements and deteriorations in reading, writing and counting were very few and roughly equal in number whether the 1977 placements or the 1980 placements were considered. It is difficult to account for the apparent deteriorations and because of this, little is made of this aspect of the study and it is not discussed below.

## DISCUSSION

This study indicates that residents transferred from a closing hospital unit do react quite strongly in the short-term in some ways to being moved from the familiar to the unknown particularly when behaviour problems, social interaction and incontinence

are considered. However, it must be remembered that some of the men were experiencing mixed sex units for the first time and this is thought to have resulted in some of the effects which have been observed and described. It must be encouraging and gratifying to staff who have worked hard to help the residents that the effects on incontinence and social interaction are not necessarily long-term in their duration. However, long-term effects on behaviour have been found: improvements and deteriorations balancing out.

The lessons we can infer seem to be that we must expect multiple transfers to lead to more deteriorations in behaviour than improvements and that stability helps residents settle down once they have made a move. One resident who had had several moves since he left Hollow Meadows summed up the position admirably when one of the authors visited his latest unit to collect information about him "You are not going to move me again are you? I like it here". What may be best for residents as far as staff are concerned from the points of view of stimulation, quality of life etc. is not always appreciated from the residents standpoint. Some apparent deteriorations in behaviour were seen as *progress* by staff as they felt it was better for residents to respond to stimulation albeit in an inappropriate way than to remain withdrawn and unresponsive as was the case at Hollow Meadows in the admittedly "custodial" régime. What was considered normal behaviour there was not acceptable following the transfers to other (perhaps mixed sex) units. Another factor which may be relevant is that even in cases where residents remained in the units to which they were originally transferred, they have been subjected to influences which may affect their behaviour. For instance, good behaviour can be used as a 'carrot' for moves desired by residents or as a threat if moves are not desired! Also because of other hospital closures, there has been a considerable degree of movement of residents generally between mental handicap residential units in Sheffield. Inevitably these have involved *internal* re-arrangements within units, to accommodate those moving in and to achieve the objectives of the units. Relationships have therefore had the opportunity to be disturbed on many occasions since 1976. The effects of such internal reorganisations have not been studied in this report but the degree of stability of residents since 1976 has been surprisingly high considering such factors. After one such move one resident who moved from a hospital which closed in 1980 to a new unit was very disturbed. The nurse in charge described the position as follows: "All this behaviour is a direct result of the move. He used to go around with other residents to social clubs etc. Where can I let him go here? I can't even let him out of these four walls. The residents are so confined and have nowhere to walk." The behaviour of ex-Hollow Meadows' residents must be seen within the context of these indirect influences upon them caused by internal and external reorganisations necessitated by the closure of other units and the confinement which has often resulted.

Other short- and long-term changes in the residents seemed to depend on the 'norms' of the units to which they were transferred particularly as far as self-help skills are concerned. For example, just because a person is 'clean' in one unit does not mean that he will remain so on transfer to another when judged by the 'hygiene' standards in that unit. Aging effects interacted with the effects of transfers, in some cases accelerating deterioration in one field of behaviour or another (*e.g.* walking), in other cases preventing improvements (*e.g.* feeding) despite increased supervision at meal times. Improvements in dressing skill can be put down to improvements in personalised clothing and the teaching of those skills. In the case of washing we have been given evidence which cannot be presented here that the original assessments of this item were unreliable and so we are unable to discuss this further. The deterioration in productive speech of those originally transferred to old hospital units is probably linked with a similar decline in social interaction (see above) but why this was not also true for those transferred to new hospitals and hostels is not clear. It may be related to the capabilities of residents.

Transfers of residents between units can and do influence visiting by relatives which may take time to rearrange. However, it was found in this study that the long-

term effect was neutral. Since changes in visiting frequency can be caused by factors outside consideration (e.g. the health of relatives), it is wisest not to make too much of the findings. In view of the multiple transfers, the length of stay of many of the residents (without close relatives) and the fact that many originated from outside Sheffield the results are perhaps not surprising. It is perhaps disappointing in some ways to have to conclude in retrospect that the siting of the old unit does not appear to have affected contact with relatives overall in the long-term. Since it is one of the principles of 'community care' to site services in proximity to the served population, one must hope that this conclusion will not apply to young mentally handicapped people admitted to residential care in the future when original placements are made with this principle in mind. A thorough investigation of the effect of siting, age, type of unit and distance on visiting frequencies of residents in all residential units in Sheffield is given by Barnes and Dalgleish (1981).

Whilst there were perhaps fewer benefiting from increases in education in the long-term than the short-term there has nevertheless still been a noteworthy long-term increase in employment and education amongst former residents of Hollow Meadows. The effects of multiple transfers and of a reduction in ex-Hollow Meadows' residents seen by teachers in one new hospital unit have been the main factors which account for these differences between the short-term and long-term. Some residents in all units are now considered too old for education and have been taken off the hospital school registers to enable more constructive work to be undertaken with the younger ones who it is felt will benefit most from the service. It is considered impossible with present teacher/resident ratios for all residents in new hospital units to receive full-time education from teachers as the total numbers of adults in the new hospital units have grown almost four-fold in the period of this study following closures of other old hospital units. The aging factor also led to other problems in the new hospital units since residents have had to stay in the small 'cottages' during the day to a far greater extent than was envisaged in the design of the units. A move to a hostel usually was followed by the provision of an A.T.C. place and a transfer from a hostel to a hospital usually meant that A.T.C. attendances stopped (sometimes as a result purely of transport problems). Such moves particularly affected the education/employment received by those residents who had multiple transfers.

There is one major difficulty in interpreting the results of this study. It is known that some multiple transfers occurred either because of inappropriate initial placements on the closure of Hollow Meadows or because the individual concerned changed. The majority of multiple transfers occurred because of reasons directly or indirectly caused by closures of other units. In this state of affairs, it would be unfair and unwise to try to account for the long- and short-term changes in the ex-Hollow Meadows' residents purely in terms of the effects of the original transfers. The picture that we are trying to present is one of complex change throughout the entire period since Hollow Meadows closed arising partly because of inappropriate placements originally but also because of reasons connected with other hospital closures (and complicated still further by effects of aging and development in the individuals concerned). In the absence of an interim assessment immediately after the closure it would therefore be impossible to disentangle what has happened and to make inferences about the long-term effect of the closure on the residents involved. The fact that an interim study was carried out has enabled some conclusions to be drawn from the latest data about long-term effects. Those who wish to know more about the long-term changes in a sample of residents from *all* residential units in Sheffield over the past few years are referred to Malin, 1981.

In this report it has been found that no less than half of the residents have been subjected to further disturbances because the original placements were not suitable or because the unit to which they transferred itself closed! This has affected staff workload as well as the residents themselves and we feel this could have been avoided given more thorough assessments originally and a longer period over which to phase the

original closure. It is interesting to see that the ramifications of these initial problems have persisted and have been confirmed over the long-term in this report. Short-term economic expediency can lead to long-term difficulties which take many years to sort out. It is suggested that transfers from a unit due to close should be based on a more detailed multidisciplinary assessment of needs in order to minimise the disturbances we have described.

We think this study illustrates the possible far-reaching consequences of multiple transfers and find it encouraging that the latest hospital closure proposed in Sheffield has been agreed some 18 months in advance of the tentative closure date. There is therefore the opportunity to assess residents for and plan transfers in a more satisfactory way so as to minimise the potential short- and long-term effects described in this paper. We hope there may be lessons in our story for others in a similar position dealing with the partial or full closure of an old mental handicap hospital.

### SUMMARY

The study follows up the movements of and progress made over a 4 year period by a group of 83 ex-residents of an old mental handicap hospital which closed in early 1977. Results are interpreted in the form of lessons which can be learned regarding recommended practice for future hospital closures.

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