MENTAL DEFICIENCY SECTION

Memorandum on the Present and Future Development and Organization of Mental Handicap Services

Present Hospital Services

There are approximately 50,000 mentally handicapped patients in hospitals, the majority of whom have no prospect of being able to live in the community, by virtue of their disability and/or lack of appropriate facilities outside hospital. It is clear that hospitals must remain responsible for this group for the forseeable future and hence their resources must not be reduced. Indeed, the standards in these existing hospitals must not only be maintained, but improved.

The hospital has a dual function: to provide medical (physical and psychiatric) care and a supportive environment. The total pattern of living of the patient cannot be separated from his treatment. For some patients who are adaptable, the sheltered environment of the hospital is necessary for their rehabilitation, and it would be desirable to see further development of pre-discharge units. At the same time, it must be recognized that a proportion of the mentally handicapped population, by virtue of the nature of their handicap, need hospital rather than community management. We support the principle of providing as normal a domestic living environment, whether in the hospital or in the community, as is compatible with the degree of mental or physical handicap.

A large number of hospitals in this country form the basis of the services for the mentally handicapped, in providing not only long term residential care but also other facilities for the community. Amongst these facilities is the provision of short-term care, which has proved invaluable in the prevention of family crises and breakdown, and it is desirable that this should continue to be available. It is important to understand, therefore, that the hospital cannot be considered as being separate from the community.

Local units should continue to be responsible for ongoing care, but regional centres should be established to provide the more specialized services, such as detailed assessment or security units for patients who do not require the maximum security provided by the Special Hospitals. In some places specialized services are provided by collaboration between the different disciplines. This is particularly apposite to meeting the needs of those with multiple handicaps such as the blind or the deaf.

Certain hospitals represent centres of excellence in the care for the mentally handicapped in the provision they make in medical, para-medical and nursing spheres. The more selective we are in admitting the mentally handicapped to hospital on purely medical and behavioural grounds the more we will require emphasis on nursing skills. If these hospitals which set high standards of attainment were to be run down or their personnel disbanded and scattered, expertise would be wantonly squandered. Increased resources are needed to improve the less well-endowed hospitals, thus raising rather than lowering overall standards of expert care.

At many points the frontiers of medicine have been advanced by research into mental handicap which could not have been carried out except in the setting of a hospital.

It is essential that the existing network of hospital services should not be abandoned, particularly at this time of national financial stringency with inadequate alternative facilities.

There is, in fact, a great shortage of places for the mentally handicapped not only in hospitals but also in the community. Urgent consideration should be given, in the present serious economic climate, to the erection of additional temporary buildings within the hospitals, as no land purchase would be involved and some of the present deficiencies could be remedied expeditiously.

The Secretary of State for the Social Services made a statement on mental handicap policy on 26 February 1975 at the National Society for Mentally Handicapped Children's Conference on 'Mental Handicap—Deployment of Resources'. We reject, in the context of the hospital services, the suggestion in paragraph 26 that mental handicap should be regarded as a social or educational responsibility rather than a health one.

No hospital, if it is to remain a hospital, whole or in part, can be run non-medically. In this connection, we draw attention to the standard contract of hospital consultants with respect to the care and legal responsibility concerning patients.

The multi-disciplinary hospital team must be led by the consultant who has full ultimate clinical responsibility. It is vital for it to be made absolutely clear that there are no areas in the management of patients in hospital that do not come ultimately under his aegis.

In paragraph 18 of the statement by the Secretary of State it is stated that 'One consequence of any

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strategic White Paper like that of 1971 is that it may often—as indeed it did—raise expectations well above the targets it sets. In fact, as measured against those targets, the shortfalls have been fairly small'. It has been very far from our collective experience that the shortfalls have been fairly small. Indeed, since 1971 there has been an increased burden on the hospital above that contemplated in the White Paper at a time when finances were being diverted away from the hospital service.

The lack of progress in collaboration and joint planning between health and local authorities, referred to in paragraph 20, has been due, in part, to the chaos of reorganization, but the proliferation of administration is an even greater impediment. Well-meaning but conflicting messages emanating from Hospital Inquiries and Advisory Service reports and Departmental pronouncements have had a damaging and demoralizing influence.

Paragraph 21 refers to the slowness of progress in changing staff attitudes, but those of us who have continued in this service and striven to improve it must reiterate that traditional practices are often consequent upon the regimentation imposed by a situation of poor staffing and inadequate facilities and can only be effectively changed by improving the iniquitous living and working conditions still existing in many hospitals throughout the country.

Responsibility of Consultant Psychiatrists in Mental Handicap

The clinical responsibilities of all consultants in psychiatry are clearly defined by the General Medical Council, the Mental Health Act and ethical practice. In this there is no basic difference between the situation for consultant psychiatrists in mental handicap and other consultant specialists.

The primary responsibility of the consultant psychiatrist in mental handicap, as of other consultants, is the diagnosis and treatment of patients referred to him. However, he may also be involved in giving advice and guidance to families and relevant community agencies.

The current uncertainties regarding the role and responsibility of the consultant psychiatrist in mental handicap are the consequence of changing concepts in approaches to the care of the mentally handicapped.

Much has been achieved by the introduction of modern caring innovations within the existing system, dependent upon the co-operation of all concerned disciplines. This however, has led to certain anomalous situations and misunderstanding.

The issuing of apparently conflicting statements by the Government, and the tendency of other disciplines to anticipate the changes they desire, has made the present situation both difficult for the consultant and potentially hazardous for the patients in his care.

Present Community Services

Many mentally handicapped people living in the community will probably need special services at some time in their lives, and too frequently such facilities are rudimentary or even absent; thus great care must be exercised to ensure that existing resources are husbanded and effectively used and that deficiencies are made good as soon as possible.

As in hospital, many different professions contribute to the care and support of the mentally handicapped and their families. The general practitioner has a central role in domiciliary practice, assisted by the health visitor, the social worker and the nurse attached to the practice.

A wide spectrum of residential facilities exists outside the hospital for the mentally handicapped, including hostels of various types, sheltered housing projects, lodgings and fostering schemes. Day nursery and day hospital places are especially valuable. Guardianship systems are also in operation in some areas. Many of these schemes depend on the back-up of hospital services. Improvement in arrangements to meet the medical and para-medical needs of mentally handicapped children and adults in the community is called for, e.g. physiotherapy and speech therapy services, special care units for children.

In some special schools a multi-disciplinary review system ensures co-ordination between the community physician, head teacher, the educational psychologist and the consultant in mental handicap.

In the evidence to the Committee of Inquiry into Special Education (Warnock Committee) the College has pointed out that it welcomes the development by Local Authorities of special educational provision for disadvantaged pre-school children and their mothers. Furthermore, the College supports the development of self-help groups, parent groups and other sources of information for parents of handicapped children. It recommends that parents should be included in the multi-professional team discussion in the assessments of their pre-school children.

The extension of pre-school education generally is welcomed. Wherever possible handicapped children should be educated alongside their normal peers. The needs of the handicapped child should be remembered in planning further nursery school provision. However, consideration should be given to a small number of children who suffer from

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handicap which necessitates special provision. Highly specialized nursery schools should be available for such children.

The school-leaving age should be flexible. Some school leavers have special medical and para-medical needs, and the responsibility for providing facilities for them is best shared between health, social and educational services. Some mentally handicapped children are able to remain at school after the age of 16 years, increasingly devoting the latter years to social and occupational training for adult life. Further education, even beyond the twenties, is important. All need social training and peer group situations outside working hours, and some need evening classes. Joint education and social service courses are often helpful.

Adult training centres frequently exclude the profoundly handicapped and those with behavioural disorders, and the combined resources of Health and Social Services should be directed to meet their needs, preferably in the vicinity of their homes.

There is a variable need for industrial workshop places, depending on local employment situations.

In adverse economic climates and with the increasing complexity of industry many of the mentally handicapped are unable to gain and hold competitive employment, but all those who work in sheltered employment should receive a realistic wage.

Voluntary Services

These are welcomed as a supplementary facility but must not be regarded as an alternative to professional care.

Future Developments

There is a great need for research into the overall requirements of the mentally handicapped and into the apportionment of hospital and community provisions. Flexibility must be retained so that new and differing patterns can be developed in different areas, depending on existing local facilities and financial resources. However, it is essential for the effectiveness of new patterns of care to be proved by research programmes before they are accepted as national policy.

We would subscribe to the establishment of an integrated service for the mentally handicapped to make maximum use of existing and future resources.

In 'Management Arrangements for the Reorganization of the National Health Service', paragraph 2.46 states 'In order to carry out planning of the operational health-care services, the DMT will establish a number of multi-disciplinary health-care planning teams to concentrate on planning services to meet particular groups of needs', and paragraph 2.49 states 'The role of the health care planning teams will be to assess needs in order to effect changes in services'. We would strongly support the establishment of health care planning teams, and regret that this has not yet become a universal practice in the mental handicap service.

There is a large socio-educational element in all cases of mental handicap and in many there is a medical component. In an integrated service consultants in mental handicap should be appointed jointly to the hospital and to the community which it serves.

The role of the mental handicap nurse for the community should be extended. He or she will require further training for this, as will the increasing number of residential workers in the community service.

We believe that future training programmes for residential care personnel in an integrated service should be a joint responsibility between the GNC and the CCETSW. This should allow flexibility of service personnel and a mutual appreciation of the difficulties.

There is a great need to develop and improve local facilities for holiday relief for parents in many areas, and to utilize available accommodation in educational and other buildings within resort areas.

Parental study groups, discussion groups and care groups are helpful for patients, their families and professionals alike and should be more widely introduced.

The provision of adequate and appropriate recreational facilities is essential to a comprehensive community care programme. Normal leisure opportunities in the locality should be used to the full, but some facilities for the handicapped need to be specially provided. We recommend the appointment of a leisure activity organizer in each locality to run youth and social clubs for the handicapped and summer camps, and to promote the development of a wide range of recreational activities, in conjunction with other centres of leisure activities.

The mentally handicapped are living longer. Parents worry greatly as to the fate of their offspring after they have died. We support the idea of guardianship schemes to keep the mentally handicapped in their homes as long as possible, sometimes with the aid of housekeepers or, alternatively, using trustee systems to help ageing mentally handicapped people to keep their rooms and their possessions.

A current Scandinavian view is that mentally handicapped persons have a right on reaching maturity to independence away from the family,

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and, moreover, that the family has the right to be relieved of the burden of care once schooling is completed. This view deserves consideration.

Voluntary services should be encouraged. This could be achieved by such occasions as One-to-One Open Days and student working parties. These help to increase community understanding of the mentally handicapped and their integration with the community.

Summary and Conclusion

It must be recognized that the hospitals for the mentally handicapped and the services they provide, should be not only conserved but improved. This will enable them to be developed with flexibility to meet the diversity of needs in different areas, and the hospital-based teams to function to their full potential.

The importance of developing comprehensive and balanced services must be taken into consideration as provisions for residential accommodation, occupational facilities and recreational facilities are often out of phase.

The suggestion is rejected that mental handicap should be regarded as a social or educational problem in isolation from its medical aspects. Consultant responsibility is delineated. No hospital, if it is to remain a hospital can be run non-medically in whole or in part, and the leadership of the hospital team must be with the consultant who has full ultimate clinical responsibility.

Alongside the hospital services we welcome the development of community facilities and we recommend a pattern of services that is adaptable and which can be modified to meet the particular needs of the locality served.

The opinions of the members of the Mental Deficiency Specialist Section appear to be a continuum. At one end of the spectrum are those with a wholly biological and scientific approach. At the other are those with a wholly operational approach in the socially orientated sense. The continuum rests on a bedrock of common agreement that the optimum must be achieved for the welfare of mentally handicapped people to whom we have a responsibility.

APPENDIX

Submissions by the Western Regional Division (Mental Deficiency Section)

Incidence

The known prevalence of mental deficiency in a community is influenced by many factors—the most important being:

1. The extent to which facilities are provided;
2. The state of economic development of the community;
3. The life expectancy of the mental defectives.

Mental deficiency is presumed to exist when the level of intelligence is more than two standard deviations below the mean level, and in the tests commonly used in this country where the mean IQ is 100, an IQ below 70 is taken as constituting mental deficiency. On theoretical grounds, and as the tests have been standardized, this should include 3 per cent of the population (Ref 1) but in practice very few surveys have shown such a high level, although the 1967 survey amongst the rural white population in Rose County, USA (Ref 2) reached this level. There are many reasons—medical, educational and social, for dividing mental defectives into two groups—a lower group with an IQ below 50 (also called severely subnormal) and an upper group with an IQ of 50–70. This lower group is more easily recognized.

The Severely Subnormal

The results of some surveys into the prevalence of severe subnormality are shown in Table I.

It should be noted that the proportion in the younger age groups exceeds that in the population as a whole—this is because the severely subnormal have a lower than average life expectancy. It can also be seen that in the 15–19 year age group, six of the eight surveys have levels above 4·5/1,000 and there is no doubt that the Newcastle and Budapest surveys will show similar levels when the populations in these surveys reach this age group. The severely subnormal are now living longer than in the past, and the prevalence of severe subnormality at age 15–19 years is likely to remain fairly stable until about age 45 years, and thereafter can be expected to drop steeply in the idiots, but more gradually in the imbeciles until age 70 years, (Fig 1 (p 19), Ref 21) illustrates this.

In trying to get a realistic assessment of the numbers of the severely subnormal, a rate of 4·5/1,000 applied to those up to age 50 years and a rate of 2/1,000 from age 50–70 and nil thereafter would give a minimum figure. The number who require to come into hospital increases with age and

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TABLE I

Prevalence

Severe subnormality (IQ >50: imbeciles and idiots)

Reference	Survey		Rate per 1,000 population		
	Year	Place	All ages	10–14 years	15–19 years
3	1929	England	2·15	–	–
4	1960	Middlesex	1·18	3·61	–
5	1963	Wessex	1·87	–	3·65
2	1967	USA (Rural whites)	4·41	–	4·57 (10–19 yrs)
6	1969	Sweden (Urban)	2·49	4·58	4·68
24	1970	Newcastle	–	4·9 (5 yrs)	–
7	1971	Netherlands	4·07	6·6 (M) 4·7 (F)	5·6 (M) 4·4 (F)
8	1971	Northern Ireland	2·79	4·11	4·73
9	1971	Budapest	–	4·5 (7–10 yrs)	–
10	1972	NE Scotland	2·9	3·6	3·7
11	1972	Bristol	–	5·19	5·5
12	1974	Eire	3·78	5·45	5·17

by age 45 years almost all require hospital care. In 1964, 67 per cent of the Glasgow MD hospital beds were occupied by those with an IQ of less than 50, which is about 1·2 beds per 1,000 population. (Ref 19). With the increasing length of survival the present needs cannot be less than this, and future hospital requirements will be significantly greater than this.

Comprehensive Surveys

When one comes to consider the total numbers of the mentally subnormal in a community, comprehensive surveys are more difficult to obtain, but Table II shows some of these.

The survey from the Netherlands is the most comprehensive—most of the others are based on the numbers making use of the services provided, and for these the most reliable figures are those which are concerned with the later school years, and these also are shown in Table II. The highest level in the school age group is that from Newcastle, and this is from a prospective survey of all children aged 9–10 years and so is not based only on those using a service. The Amsterdam survey also covered all children in specific age groups, whereas the survey in Glasgow covered only those making demands on the service. These three levels of about 16/1,000 at school age are from large cities, whereas the other two surveys showing lower levels of 14·8/1,000 included rural populations as well as smaller towns. These totals include those who are severely subnormal, which, as shown above, are almost 5/1,000 at school age. In the later school years (10–14) both the NE Scotland and the Northern Ireland surveys

TABLE II

Mental deficiency rates per 1,000 population

Reference	Year	Place	Totals	
			All ages	School age
13	1904	England	4·6	–
3	1929	England	8·6	–
5	1963	Wessex	3·35	–
14	1964	Glasgow	8·97	15·87 (5–16 yrs)
24	1970	Newcastle	–	17·3 (9–10 yrs)
7	1971	Netherlands	12·57	16·15 (Amsterdam 10–13 yrs Ref 16)
8	1971	Northern Ireland	4·07	14·8 (10–14 yrs)
15	1972	NE Scotland	6·4	14·76 (10–14 yrs)

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found the incidence of those with an IQ of 50–70 to be 10·4 and 10·69 respectively, whilst in the Amsterdam survey it was 10·8 per 1,000.

After leaving school there are many social factors which influence the demand for services (e.g. Ref 26), and many of the less severely defective can subsist

TABLE IIIa

The frequencies of the severely mentally handicapped in the Netherlands in 1969, 1980 and 1990 and the absolute figures for 1980 and 1990 per 1,000 population (males)

Age	Males					
	freq '69	number	freq '80	number	freq '90	number
1–4	6·8	3,328	6·8	3,737	6·8	3,832
5–9	6·7	4,104	6·7	4,261	6·7	4,609
10–14	6·6	3,830	6·6	3,994	6·6	4,516
15–19	5·6	3,186	6·3	3,874	6·3	3,976
20–24	5·1	2,995	5·9	3,438	6·2	3,586
25–29	4·3	1,977	5·1	2,894	6·3	3,518
30–34	3·7	1,517	4·7	2,760	5·5	3,169
35–39	2·8	1,106	3·9	1,821	4·8	2,667
40–44	2·0	744	3·4	1,405	4·4	2,557
45–49	1·9	697	2·6	1,004	3·7	1,654
50–54	1·9	594	1·8	646	3·1	1,219
55–59	1·7	508	1·8	600	2·5	865
60–64	1·5	395	1·9	500	1·8	544
65–69	1·3	277	1·6	391	1·7	463
70–74	1·0	159	1·5	267	1·9	338
75–79	1·0	108	1·5	184	1·6	208
80 and older	1·0	93	1·5	166	1·6	198
Total population ..	4·07	25,618	4·55	31,942	4·93	27,919

TABLE IIIb

The frequencies of the severely mentally handicapped in the Netherlands in 1969, 1980 and 1990 and the absolute figures for 1980 and 1990 per 1,000 population (females)

Age	Females					
	freq '69	number	freq '80	number	freq '90	number
1–4	5·0	2,297	5·0	2,617	5·8	2,681
5–9	4·8	2,838	4·8	2,913	4·0	3,180
10–14	4·7	2,618	4·7	2,719	4·7	3,071
15–19	4·4	2,371	4·5	2,649	4·5	2,719
20–24	4·2	2,360	4·2	2,350	4·2	3,441
25–29	3·4	1,452	4·0	2,153	4·1	2,406
30–34	3·2	1,224	3·9	2,175	3·9	2,166
35–39	2·8	1,065	3·1	1,338	3·7	1,984
40–44	1·6	603	3·0	1,134	3·6	2,015
45–49	1·2	458	2·6	967	2·9	1,215
50–54	1·1	361	1·4	523	2·7	984
55–59	1·0	325	1·1	394	2·3	833
60–64	·8	240	1·0	304	1·3	441
65–69	·7	179	·9	251	·9	304
70–74	·5	101	·6	162	·8	206
75–79	·5	70	·6	113	·8	172
80 and older	·5	62	·6	110	·8	114
Total population ..	2·93	18,623	3·22	22,872	3·45	26,932

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in the community without making special demands, but there is no doubt that if reasonable services are provided the demand expands to make use of them. The prevalence of almost 9/1,000 for all ages for Glasgow in 1964 was a minimum indication of demand before the passing of the Social Work Act (1968) laid down increased responsibilities for community care. Because of the greater stresses of industrial communities there is usually a greater need for services in urban areas than in rural ones, and this is borne out by comparing the overall figures in Table II for Glasgow with those for NE Scotland and Northern Ireland.

Trends

Mental defectives, like the rest of the population, are living longer, and the life expectancy of those with an IQ above 50 is approaching that of the general population. For those with an IQ below 50 life expectancy is still less than average, but much more than it used to be (Fig 1).

In discussing his 1971 figures, Verbraak (Ref 7) suggested that the increase shown over the 1960 Middlesex figures (Ref 4) was due to the lower infant mortality rates in the Netherlands. The infant mortality in the UK has continued to decline since 1960, and the more recent figures, such as from Bristol in 1972 (Ref 11) are certainly more in keeping with the findings in the Netherlands (and Sweden).

In the Netherlands minimum projections based on the 1969 incidence of mental defectives have been made for 1980 and 1990 (Ref 7). Tables showing these projections are reproduced as Tables IIIa, b, (p 16) and c (below).

Because of the diminishing death rate the absolute numbers surviving show a very significant increase. In another paper on forward planning (Ref 22) it is stated that the Dutch 'have to reckon seriously with a considerable expansion of the intra-mural services of at least 1,000 beds per year in the next 20–30 years'.

Mental Deficiency Hospital Populations

Trends related to the ageing of those in Institutions are shown in Table IV which is based on official statistics up to 1969 and appeared in the *Lancet* (Ref 17).

TABLE IV

Percentage distribution of mentally handicapped subjects resident in institutions in England and Wales

Age-Group (Yr)	1954	1963	1968	1969
Under 5 ..	0·68	0·83	1·14	1·18
5–	3·95	4·31	3·46	3·44
10–	7·39	6·85	6·56	6·26
15–	8·72	10·50	8·72	8·50
20–	12·03	9·29	10·56	10·09
25–	22·33	16·05	15·74	16·10
35–	19·38	16·74	15·56	15·51
45–	16·09	16·19	15·52	15·39
55 and over ..	9·43	19·24	22·74	23·53
	100·00	100·00	100·00	100·00

The increase in the proportion of those aged 55 and over in the 15 year period from 1954 to 1969 is very striking (9·45 per cent to 23·5 per cent). No doubt similar figures could be produced for the Scottish hospitals which were in existence in 1954. In his paper on 'Age Trends in Mental Deficiency

TABLE IIIc

The frequencies and the absolute number of mildly mentally handicapped males and females in 1969, 1980 and 1990

Years	number	%
1969 mildly mentally handicapped males	56,505	0·06
1969 mildly mentally handicapped females	33,972	0·64
Total	90,477	0·85
1980 mildly mentally handicapped males	61,315	1·03
1980 mildly mentally handicapped females	36,821	0·63
Total	98,136	0·83
1990 mildly mentally handicapped males	66,394	1·01
1990 mildly mentally handicapped females	39,799	0·63
Total	106,193	0·82

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Institutions' (Ref 18), Richards expands on this and relates hospital age changes to those in the general population (Table Va) and to the different grades of Mental Defectives (Table Vb). These tables are reproduced here.

TABLE Va

Percentage of subjects over 50 years of age

	MALES		FEMALES	
Year	Hospital	General Population (RG)	Hospital	General Population (RG)
1939	13·2		25·4	
1947		24·6		28·9
1949	13·4		24·2	
1953	14·8		27·7	
1960	19·1	27·4	28·3	33·2
1965	24·2	27·8	35·1	33·8
1967	24·7		35·1	

TABLE Vb

Percentage of residents over 50 years of age, by sex and grade in 1953 and 1966

	MALES			FEMALES		
Year	Idiot	Imbecile	Feeble Minded	Idiot	Imbecile	Feeble Minded
1953	0·0	14·6	24·4	2·4	26·8	38·6
1966	3·9	21·7	44·4	8·5	29·5	44·2

It is well known that there has been a significant, if gradual change in the kind of patients in mental deficiency hospitals, e.g. in Lennox Castle hospital—the largest MD hospital in Scotland, over a 25 year period from 1939 to 1964 the proportions of those with IQ above, and below 50 were:

	1939	*1964*
Feeble-minded (IQ 50–70)	44%	33%
Imbecile & Idiot (IQ <50)	56%	67%
		(Ref 14)

In the Royal Scottish National Hospital (the second largest mental deficiency hospital) a policy of selective admission has meant that 30 per cent of recent long-stay admissions have multiple handicaps (mostly severely subnormal) and the rest have behaviour disorders (Ref 19).

These changes relating to age, IQ, and kind of handicap are producing significant changes in the total hospital populations resulting in a reduction in the numbers who can be satisfactorily rehabilitated into the community. They also indicate a slower rate of turnover in hospital beds, and this is reflected in an increased waiting list (73 for Lennox Castle, and 151 for The Royal Scottish National Hospital, at 30 September 1975).

In 1974 a European Symposium was held in Luxembourg on 'New Trends in Residential Institutions for Maladjusted or Handicapped Youth'. On page 13 of the Final Report (Ref 20) there is:

'2.5—*Overall number of applications for admission and actual admissions.*

The reports treating this topic point out that, on the whole, applications for admission and actual admissions are increasing—even if they mention fluctuations and contrary movements for certain age-groups or for certain categories of children. Only in the case of two countries do we have precise statistical data on a national scale: in one case the number of admissions has doubled over a period of 15 years; in the other there has been, for the last ten years, a regular yearly increase. . . .'

'2.6—*Differential demands and changes in the population of children and adolescents.*

In several reports there is a mention of an increase in the number of applications for handicapped children, for children with social problems and for "mentally ill" children, and a relative decrease for orphans.'

The foregoing demonstrate an increase in the demand for residential care. Against this there is the fact of fewer babies being born to older mothers, and the effect of screening tests and genetic counselling. These have reduced the incidence of mongol births from 1 : 600 to 1 : 800 and there is likely to be a further reduction to 1 : 1,000 and possibly 1 : 1,200 births. The effect of these measures is likely to be small for the next 20 years, and during this period the increase in length of life will be a major factor. There is no indication of a general falling off of intelligence in the population (Ref 23).

Residential Requirements

In brief, one can expect an increase in the demand for residential places for mental defectives. In 1973 in Denmark the need for residential places was 2·9/1,000 (Ref 25). In 1964 in Glasgow the demand for hospital places for mental defectives was 1·96 per 1,000 (Ref 14). This was before the Social Work Act of 1968 and so some of this demand could be directed to Community Homes. However in view of:

1. The increasing numbers of the severely subnormal who are living into middle age;

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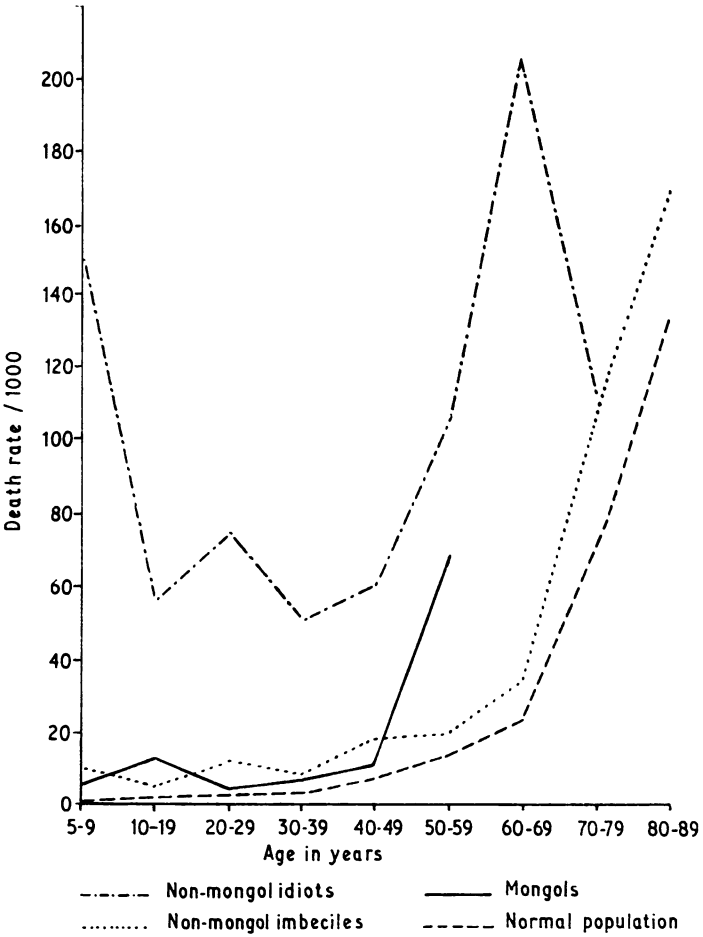


FIG 1.—1955–67: Death rates of mongols, non-mongol idiots and imbeciles, and normal population (1966) compared.

2. The numbers of the feeble-minded who are becoming geriatric;

3. The increasing demands for hospital accommodation for those mental defectives with severe behaviour disorders

the need for hospital provision is likely to be in excess of 2 beds per 1,000 population for urban areas, and somewhat less than this in rural areas.

In the community there will be an increasing demand for residential accommodation for the older severely subnormal who requires minimum care and whose relatives cease to be able to provide this, (e.g. an uncomplicated mongol) and for the older feeble-minded persons until they require hospital care. Clearly there is a need for the total expansion of residential care.

Conclusion

The needs of the mentally handicapped cannot be easily compartmentalized into social, educational and medical, and the requirements of the individual change with changes in age and behaviour, and physical disability. Because of this there are serious difficulties in providing an adequate range of services when the responsibility for this lies with different agencies. Most advanced countries, other than Great Britain, provide a centrally planned service, and the reasons for this are well set out in the article by F. J. Krause (Ref 27).

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