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International Year of Disabled Persons: The Institution in England and Wales

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The Institution In England and Wales:

Its Advent and Its Demise

By Larry Gostin

Asylums first appeared in England in the 19th century, the precursors to the institutions in North America. It is now recognized, however, in Britain as in this country, that the fundamental objectives and quality of life offered within a self-enclosed, segregated environment, are detrimental to the well-being of the mentally handicapped.¹

Unlike the U.S., though, Britain has chosen to use a legislative approach to ensure the closure of its institutions by 1990. A recent study, however, which has yet to be published, shows that the target dates for establishing community alternatives are not being met.

Larry Gostin examines these historical developments and reveals why the national policy of deinstitutionalization is encountering strong opposition.

A notable characteristic of American federalism is that domestic policy has been substantially determined by the courts. The judiciary has introduced its own social morality to ensure reasonable access to services for minority groups.

The concept of judicial policy making has found no greater expression than in the field of mental retardation where the service provided has been largely mandated by judges.

It would be improper to be over-critical of judicial intervention, particularly as it has come in the wake of chronic legislative and executive neglect of the needs of mentally retarded people. Nevertheless it is regrettable that important policy decisions which intimately affect the quality of life of mentally retarded people have had to be taken within the narrow context of litigation. The courts are limited by the particular facts and issues raised in the immediate case; they are only able to set minimal standards based upon non-specific constitutional principles which have little direct applicability to mentally retarded people; and they are ill-equipped to assure long term compliance with, and implementation of, their judgments.

Indeed, the elements which comprise sound policy and enable adequate provision of services—planning, budgeting, building, operating and monitoring—are legislative functions, and comprehensive interference by the judiciary may prove ineffective.

A mental retardation service requires a full range of provision specifically adapted to meet the needs of the individual. The broadbrush approach of constitutional habilitation and less drastic means principles are insufficiently sensitive to the individual needs of mentally retarded people to serve their long term interests.

Constitutional guarantees have, properly, ushered mentally retarded people from the institution to the community. Courts have also examined the constitutional parameters of mandating effective community alternatives through affirmative action. However, the judiciary is impeded in its ability to follow the mentally retarded citizen into the community with a view to securing his welfare; this is particularly so where the mentally retarded person ostensibly consents to residence in a privately owned facility.²

It is important that the philosophy of the institution should not find its way into the planning and development of community services. The legislature should not place great emphasis on the deficits in a person's intellectual capacity or handicapped status. By doing so, it may neglect the essentially human needs of mentally handicapped people by

subordinating them to perceived needs for custody and protection.

It is a basic strength of the English law that it ensures all citizens equal access to medical treatment³, housing⁴, education⁵, food and income maintenance.⁶ Indeed, if the status of being handicapped is relevant for any purpose it is to create affirmative priorities under general welfare legislation.⁷ The ineffectual nature of this essential legislative approach when compared to the United States is the difficulty of individual enforcement by way of administrative or judicial action.⁸

The Advent of the Idiot Asylum

In 19th and early 20th century England it was thought that life-long segregation from society was the preferred and caring response to mental defectiveness. "It was determined from the beginning," according to the National Association for the Care of the Feeble Minded, "that only permanent care could be really efficacious in stemming the great evil of feebleness of mind in our country." This was "universally regarded as the proper method of dealing with the weak in intellect".⁹ Institutions—or "colonies" as they were referred to—were in the country, some distance from centres of population and were operated as self-enclosed communities.

The specialised "idiot asylum" first developed in England in the latter half of the 19th century and found official recognition (relating to registration, inspection and admission) in the Idiots Act 1886. Idiot asylums, however, were not the predominant establishment used for the segregation of mentally handicapped people.

Mentally handicapped people were dealt with not by reason of their social disability but on their presumed association with poverty, insanity or delinquency. In 1881, a return of idiots (*i.e.* mental defectives of any grade) in public institutions totalled 29,452; and only 3 percent were in institutions specifically designed for them. The remainder were in workhouses, lunatic asylums and prisons.¹⁰

By the mid 1920's the percentage of defectives in specialised mental deficiency institutions had increased to only 10 percent; 25 percent were still in mental illness hospitals; and 39 percent were in Poor Law Institutions.¹¹ The Local Government Act 1929, which abolished the structure created by the Poor Laws, made possible the formal transfer of certain Poor Law institutions to mental deficiency authorities.

Legislative definitions relating to mentally handicapped people also provided an insight into public and professional attitudes. In the Lunacy Act 1890, a "lunatic" included "an idiot or person of unsound

mind". No distinction was made between the two conditions. This was inappropriate even by contemporary standards, for there had been wide recognition of the differentiation in the two conditions for many years; indeed, the 1886 act itself had drawn the distinction. The 1890 act represented a realisation that mental defectives would reside in lunatic asylums for the foreseeable future due to insufficient specialised accommodation.¹²

The Royal Commission on the Care of the Feeble-Minded deliberated between 1904-08. In its report¹³ it came to the conclusion that heredity was an important factor in mental deficiency, that defectives were often highly prolific, and that other social problems, notably delinquency, alcoholism and illegitimacy, were aggravated by the freedom of action of mental defectives within the community. Their principal recommendation was the segregation of defectives "to protect them from the worse elements of society" and from their own instinctual responses "because they were unfit to take part in the struggle of life." Remarkably, this was seen as a liberal proposal because it had implicitly rejected "genetic purification" as a solution which was being put forward by the influential Eugenics Society founded in 1907 and led by Sir Francis Galton.

The Mental Deficiency Act 1913 provided a structure for the protection of the mentally defective. It resisted measures for permanent segregation, however, by introducing various alternatives for control through statutory guardianship, institutional care and licence from the institution. The act further placed responsibility for the provision and maintenance of institutions and for the provision of community services for the mentally defective on local government (then the County Borough Council and now the Local Authority). The total responsibility of local government for servicing mentally handicapped people was to remain until the National Health Service Act 1948.

National Health Service Act

The National Health Service Act represented a revolution in the provision of health care in British society. Access to the care was no longer to be determined on the basis of ability to pay but on the need for treatment. Despite a previous statement to the contrary by the Minister of Health¹⁴, it was decided to include psychiatry within the NHS. A Working Party under the auspices of the predominate medical societies in the country stressed in 1945 the need for "treating psychiatry in all essential respects like other branches of medicine".¹⁵

In the new National Health Service, local authorities were to be given wide powers to provide comprehensive care and after-care in the community and to this day have principal responsibility for the care and habilitation of mentally handicapped people in the community. Hospitals, however, were to be removed from the responsibility of local government and placed under regional hospital boards (now Regional Health Authorities).

At that time, the accommodation in the former public assistance institutions, which like Idiot Asylums, performed both social welfare and medical functions, was divided between the new hospital authorities and the local authorities who retained responsibility for providing residential accommodation for elderly people. There was no similar apportionment of accommodation in the mental deficiency institutions, which all became "hospitals".

Hospitals continued to admit mentally handicapped people who needed residential care on either social or medical grounds. Indeed, if a mentally handicapped child needed only residential care, he or she would be placed on the waiting list of a hospital. The child would be reared within a health system attended by doctors and nurses among others. Peer relationships were limited to those individuals with physical and mental handicaps similar to, or more severe than, their own.

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency sat from 1954-1957.¹⁶ The Mental Health Act 1959, which was modelled on the Royal Commission Report, was generally acclaimed as being one of the most enlightened pieces of social welfare legislation in this century. It was largely responsible for the international trend toward informality and medical discretion in mental health care, and away from judicially ordered civil commitment.¹⁷

The Royal Commission report and subsequent legislation solidified the classification of mental handicap as a medical condition. More importantly, the criteria for admission to a mental handicap hospital were to be largely medical in nature, with the procedures principally in the hands of doctors and the responsibility of the hospital delegated to a responsible medical officer.

The Mental Health Act was the most recent piece of legislation specifically sanctioning the admission and treatment of mentally handicapped people in hospital. At the time the Royal Commission deliberated, there was limited understanding of the essentially developmental nature of mental handicap and of the predominant needs for education, training and socialisation. Whatever understanding there was

at the time was not reflected in the report of the Commission. There is no evidence from the terms of the Mental Health Act, or the parliamentary debates which preceded it, that detailed consideration was given to the needs of mentally handicapped people; they were forced into a legislative straightjacket which really applied to the psychiatrically ill.

The placement of mentally handicapped people in large-scale institutions, then, was not a product of a thoughtful social policy based upon contemporary evidence of the effectiveness of hospitals or a belief in their essential humanity. Rather, mentally handicapped people in Britain found their way into institutions by historical accident and this unfortunate legacy was to be passed on to Europe and North America.

The Demise of the Institution

The 1970's ushered in a new philosophy of care and humanity for mentally handicapped people in the United Kingdom. In 1971, the White Paper, *Better Services for the Mentally Handicapped*¹⁸, set out government policy and a 25 year plan which signalled the demise of the large scale residential institution and, in its place, the establishment of a comprehensive structure of care in the community.

The government first enunciated general principles about the habilitation of mentally handicapped people: a family with a handicapped member has the same needs for general welfare and social services as all families, together with special needs by reason of the particular physical or mental handicap; mentally handicapped people should not be segregated from the general life of the local community; each handicapped person needs stimulation, social training and education, and purposeful occupation or employment to develop his maximum potential capacity and to exercise all the skills he or she possesses, however limited; each mentally handicapped person should, whenever possible, live with his or her family; if it is necessary to leave home, alternative accommodation and care should be as normal and as home-like as possible and should provide sympathetic and constant human relationships; mentally handicapped people should receive comprehensive and periodic assessment of their needs and the needs of their families and comprehensive services to meet those needs, including education, social and work training, day care and occupation or the opportunity for fully remunerative employment, accommodation, advice, practical help and respite from care for the family, medical and nursing care, and income maintenance.

Each of the life needs of mentally handicapped people were assessed in detail in the White Paper.

Most noticeably, the proper role of hospitals was carefully defined.

Department of Health and Social Security figures on reasons for admission have constantly shown that substantial numbers of people enter mental handicap hospitals and other specialist facilities primarily for domiciliary and social reasons.¹⁹ The institution, therefore, has had a distinct 'hotel' or 'asylum' function, providing lodgings for vulnerable people with no home to go to. Existing legislation had the effect of encouraging hospitals and local authorities to adopt such an approach, in which fundamental 'housing' needs were obscured by a need for care.

The White Paper stated unequivocally that, as local authority residential services develop, this function of hospitals should cease. When a mentally handicapped person requires hospital treatment for a physical illness, surgery or mental illness, he should normally receive this in the appropriate department of a general or mental illness hospital.

Hospitals would also have a role to play in prevention, assessment, family counselling and day services. In-patient services would be limited to mentally handicapped people with multiple physical disability or behaviour disorder; these mentally handicapped people may have to remain in hospital permanently because they "require treatment or training under specialised medical supervision or constant nursing care". There was widespread agreement from health and social services authorities on the need to hospitalise profoundly and multiply handicapped people.

This "in-patient" function of hospitals, though, was revised by the government in subsequent policy statements. It devised detailed planning guides to shift the balance of care from hospitals to the community within a projected period of twenty years. It sought to reduce the number of in-patient beds by one-half over the projected period and to ban the further building of large hospitals. It planned a corresponding increase in community provision, including housing, foster arrangements and education.

The planning figures laid down in the White Paper are shown in Table 1 (P. 28). Methods for implementing needed changes, including research, staff training, coordination of services, building and architecture, and funding arrangements and priorities were discussed in detail in the White Paper. The government also announced it would evaluate the new pattern of services and reassess its planning figures in the future. That reassessment has now been completed, although it is yet to be published. A discussion will follow.

Subsequent to the publication of the White Paper, mentally handicapped people were formally designated as a priority group for expenditure in the health and social services sector. The intended aims of the government document on priorities were consonant with the White Paper: to ensure that mentally handicapped people have a satisfying environment (which should as far as possible be within the general community) and to provide education, social stimulation and purposeful occupation and employment to develop and exercise skills to their full potential.²⁰

Despite the broad aims of government there were still major deficiencies in implementing the planned shift in the balance of care mandated in the White Paper. As a result, in February 1975, the Secretary of State for Health and Social Services announced three new initiatives: (1) the establishment of a National Development Group for the Mentally Handicapped to advise the government on practical implementation and evaluation of the planned pattern and delivery of services; (2) the establishment of a full-scale committee of enquiry into mental handicap nursing and care; and (3) the intention to establish a National Development Team to offer advice to individual authorities and others in the planning and development of their own services within the context of national policy.

The Needs of a Profoundly Handicapped Child

The National Development Team has published detailed practical advice on the transition to a community based service for mentally handicapped people, including the most profoundly retarded and multiply handicapped children.²¹ Particular attention has been given to profoundly retarded children living on long-stay wards of mental handicap hospitals. The medical, educational and social problems of these children have appeared so intractable that they have not in many respects been regarded as within the varied fabric of humanity, but apart from it. The principle of care for these children should now be that they have "more in common with other children because of their childhood than they have with severely mentally handicapped adults because of their common disability".²²

The stated government objective is to ensure that mentally handicapped children enjoy a childhood as normal as possible. This means that they should have access to the whole range of experiences and activities available to other children, and that artificial barriers to the enjoyment of such experiences imposed by the institutional structure

TABLE 1*

Planning Figures for Services for the Mentally Handicapped Compared with Existing Provision

Type of service	Places for children (age 0-15)			Places for adults (age 16+)		
	Required		Provided	Required		Provided
	Per 100,000 total population	Total England and Wales 1969	Total England and Wales 1969	Per 100,000 total population	Total England and Wales 1969	Total England and Wales 1969
Day care or education for children under five	8	3,900	500 +	—	—	—
Education for children of school age:						
In the community—						
(i) for children with severe mental handicap living in the community	56	27,400	23,400	—	—	—
(ii) for children coming by day from hospital	6	2,900		—	—	—
In hospitals—						
(iii) for in-patients	7	3,400	4,600	—	—	—
(iv) for day patients	6	2,900	200	—	—	—
Occupation and training for adults:						
In the community—						
(i) for adults living in the community	—	—	—	130	63,700	24,500
(ii) for adults coming by day from hospital	—	—	—	20	9,800	100
In hospitals—						
(iii) for in-patients	—	—	—	35	17,200	30,000 +
(iv) for day patients	—	—	—	10	4,900	200 +
Residential care in the community (including short-stay):						
(i) in local authority, voluntary or privately owned residential homes	10	4,900	1,800	60	29,400	4,300
(ii) foster homes, lodgings, etc.	2	1,000	100	15	7,400	550
Hospital treatment:						
(i) for in-patients	13	6,400	7,400#	55	27,000	52,100#
(ii) for day patients	6	2,900	200 +	10	4,900	500 +

+ Estimated.

NHS beds allocated to mental handicap.

* Department of Health and Social Security and Welsh Office, *Better Services for the Mentally Handicapped*, Cmnd. 4683 (1971).

should be removed. Slowly, the government's sole justification for retaining the in-patient residential function of mental handicap hospitals has been withering away.

In 1978 the National Development Group and a Department of Health and Social Security sponsored study²³ both cast still more serious doubts about the propriety of long-term hospital care for handicapped children. The fundamental needs of children for mothering, warmth, social interaction, attention and play were being largely disregarded in hospitals. The research indicated that institutionalised children received an average of five minutes mothering attention (cuddling, touch, play and talking to) in a ten hour period and less physically attractive and able children received far less attention.

Children were living in such physically and emotionally sterile environments that they sought occupation from playing with the straps of wheelchairs, sucking their sleeves or playing with their own saliva. This was a form of institutional play and a means of filling time. Children also emulated each other's habits, and stereotyped maladaptive behaviour was passed from one generation of children to another.

Many children did not display the same peculiar behaviour patterns during fully occupied hours, such as when they were in school. The institutional environment was causing children to feel, and to learn, aloneness and isolation, deeply impeding their development by keeping them devoid of human involvement and communication.

Even the general medical care for which children were ostensibly placed in hospital was well below the standard of non-handicapped children in the community. Practical examples included failure to remove operable cataracts to restore vision (because of management difficulties associated with the newly found experience of sight), teeth extracted to prevent aggressive biting and basic dietary diseases and insanitary conditions.²⁴

It is important to observe that other basic research had established both the damage caused by institutions as well as the feasibility of alternative models of care. Studies comparing Down's syndrome children at home and in institutions had found the home-reared group to be superior in intellectual and social development.²⁵ Other research pointed to the capacity of families, given adequate support and guidance, to raise their mentally handicapped children at home, and to the problems produced by early hospital admission.²⁶ Where natural parents were unable to cope, pioneering work in a project by Dr. Barnardo showed that these children could be placed in warm foster homes and integrated into

ordinary children's homes,²⁷ while the Wessex project demonstrated the particular feasibility of locally based residential care for the most severely handicapped children and adults.²⁸

Mental Handicap Policy into the Eighties

The government has undertaken a comprehensive review of policy and of the progress in implementing the initial White Paper objective of a fundamental shift in the balance of care. The review was commenced in 1978 and should be released in due course; therefore, the examination herein should not be regarded as a definitive representation of government policy prior to the publication of the review.

The White Paper set targets for 1991 for hospital places for adults and children. There has been a marked difference in developments since 1971 for each of these groups so they will be examined and analysed separately.

The number of children in mental handicap hospitals has significantly declined since 1971 to well below the level envisaged in the White Paper. (See Table 2.) It is difficult to assess the reasons for the reduction in the number of children in mental handicap hospitals. Certainly there has not been a corresponding growth in the number of residential places in the community for children. The White Paper, however, envisaged increased support to families of mentally handicapped children which has reduced the need for residential care.

The emphasis of both health and social services has been increasingly on maintaining the child within his own family by providing practical help, counselling, income supplements and respite from care. A policy of providing substitute (foster or adoptive) homes was also envisaged in the White Paper and is reaffirmed in the current review.

This positive community support system is not the only reason for the decline in the number of children in hospital. Some hospitals have a policy of not admitting children under any circumstances, although this unilateral withdrawal of National Health Service places without ensuring by joint planning that appropriate alternatives are available is against national policy.

The most important development of policy in the current government review is a modified reversal of its policy for future services for mentally handicapped children: "The time has come to state unequivocally that large hospitals do not provide a favourable environment for a child to grow up in." Despite this "unequivocal" statement, the government only altered the 1991 planning target to reflect

the 1977 census in hospital care. It reserved its judgment as to whether mentally handicapped children should ever be in hospital on a long-term basis.

The reduction in the number of hospital places for mentally handicapped adults has not been as encouraging. (See Table 3.) The number of adults has decreased by over 600 a year since 1969 compared with a slight increase between 1963 and 1969. This fall, however, has not met White Paper targets despite meeting the objectives set by the White Paper on the planned rate of residential community care.

It is apparent that health and social services authorities have concentrated more on preventing inappropriate admissions than on discharging people inappropriately residing in hospitals. The government review encouraged an acceleration of the discharge rate of mentally handicapped adults and set lower target figures for places in mental handicap hospitals.

In sum, there has been a significant shift in the balance of care since the White Paper. However, there are still marked deficiencies in the provision of a full community service for mentally handicapped people. Nearly one-third of the 130 local authorities have no residential places for children, and overall, they have only established one-third of the residential care planned for 1991. Over 40 percent of all residential homes for adults are larger than the maximum size of 25 recommended in the White Paper.

There are some 45,000 adults and 3,000 children who still live in hospitals and, despite the gallons of paint and acres of furnishing poured into these hospitals, recent enquiries²⁹ and the government's own National Development Team³⁰ suggest that standards are once again falling. Many local authorities have not heeded the government's planning targets nor its insistence on mental handicap as a spending priority. In order to understand why these goals have not been met, it is necessary to examine the obstacles to implementation of a full community service for mentally handicapped people.

The White Paper was written at a time of economic expansion. Since then restraint in public expenditure has meant a reduction in real growth in the health and social services sector. This has had a profound affect on community services for mentally handicapped people despite it being designated as a priority.

Between 1974/75 and 1977/78 the identifiable mental handicap share of expenditure on health and personal social services remained virtually static; in these two years the shares were 4.5 percent and 4.3 percent respectively. These figures, however, conceal the important fact that the mental handicap share of revenue expenditure on personal social ser-

VICES has increased appreciably during the period of restraint enabling wider provision of community services. At the same time, their share in respect of revenue expenditure on health services and capital expenditure on health and social services has either been static or has been reduced.

These facts are most instructive in assessing the future of mental handicap services in England and Wales. The current government is wholeheartedly committed to severe public spending cuts in the future. It concedes, therefore, that "at least in the medium term, community care services may not develop at the rate needed to permit changes in the hospital service." It suggests that "the pace of discharge from hospital may slow down." "There might also be forced expenditures on outdated stock and a continuing need for large hospitals for longer than had been expected."

This raises significant ethical and policy issues which the government has not addressed. First, the recent evidence showing a fall in the standards of mental handicap hospitals is not surprising given the sharp decrease in capital and revenue expenditure on the health services. The peculiar nature of a large Victorian institution is that reduction in the number of people resident in them does not necessarily mean a corresponding reduction in the cost of operating the institution. The principal costs of heating, light and maintaining the institution do not decrease substantially with a reduction in resident population.

Thus, to the extent that the government operates dual or parallel systems of care (one population segregated in outdated and very large establishments and the other integrated into the community), it will have to provide ever-increasing expenditure simply to maintain the existing quality of life for mentally handicapped people. The ethical dilemma is that if the government shows positive discrimination in favour of community services by restricting expenditure on the institution, it will severely affect the quality of life of in-patients and the morale of staff.

Indeed, both of these problems are occurring at a disquieting rate in many institutions. In a period of financial restraint it is tempting to renew outdated hospital facilities rather than embark upon new initiatives within the community. The government hints that this may, in fact, be its approach in the early 1980's. This would be a retrograde step in government policy. It is, furthermore, a costly policy in the long term because it perpetuates the duality of mental handicap services and commits almost limitless funds to continue to maintain standards within badly deteriorating institutions.

The Royal Commission on the National Health Service recently recommended the abolition of mental handicap hospitals which were "very isolated, in very bad repair or are obviously redundant due to major shifts of population".³¹ It is certain that a great many mental handicap hospitals would meet these criteria.

MIND has estimated that the potential revenue that would be accrued from dismantling large mental handicap hospitals and selling the land would be sufficient to provide mentally handicapped people with a fundamentally higher quality of life within the community. This is a politically difficult decision to make, particularly because the financial rewards

TABLE 2.1 Children in Mental Handicap Hospitals and Units

	<u>Children aged 0-15</u>		<u>1991 White Paper target for Children's Places</u>
	<u>1969</u>	<u>1977</u>	
Numbers	7,100	3,900	5,200
Rate per 100,000 population aged 0-15	62	35	53

TABLE 2.2 Places in Residential Homes for Mentally Handicapped Children

	<u>Provided 1969</u>	<u>Provided 1977</u>	<u>1991 White Paper target</u>
In LA homes*	1,200	1,600	Not specified
In all homes	1,700	2,200	4,000
Rate per 100,000 population aged 0-15	15	20	40

*Local Authority

TABLE 3.1 Adults in Mental Handicap Hospitals and Units

	<u>Adults aged 16+</u>		<u>1991 White Paper target for Adults' Places</u>
	<u>1969</u>	<u>1977</u>	
Numbers	49,200	44,100	27,300
Rate per 100,000 population aged 16+	142	125	74

TABLE 3.2 Places in Residential Homes for Mentally Handicapped Adults

	<u>Provided 1969</u>	<u>Provided 1977</u>	<u>1991 White Paper target</u>
In LA homes	3,100	8,100	Not specified
In all homes	4,200	11,700	30,000
Rate per 100,000 population aged 16+	12	33	81

would be achieved only after a planned phasing out of remote institutions. It is also politically difficult because of the employment and retraining implications represented by the demise of these institutions.

Britain does not have the same form of federalism as in the United States. Nevertheless, regional and local governments do have a certain amount of autonomy in the way they spend their resources. Many local authorities have not given mental handicap services the priority position recommended by the government. Furthermore, the government has rejected proposals to earmark funds for use on mentally handicapped people in deference to its general policy of local spending autonomy. Instead, the government has stated that it will increase joint funding whereby grants are given to health and social services authorities to spend on common projects.

It is suggested that the need to ensure that priority is given to mentally handicapped people outweighs the general desirability of local autonomy; national government should further consider the desirability of designating funds for expenditure on mental handicap services.

One of the most serious problems associated with a massive shift in resources from hospital to community care is that it would significantly affect the employment of staff in mental handicap hospitals. Large hospitals which are built in isolated communities sometimes are the primary employers in the area. Entire communities would, therefore, be adversely affected if the institution were closed.

Members of staff—particularly nurses who represent the backbone of the hospital service—perceive closure as a threat not only to their home and community, but to their livelihood. Accordingly, health service unions have been in the forefront in Britain in resisting efforts nationally and locally to dismantle large institutions. Indeed, there is some justification for their perceived fear because successive governments have not developed policies of retraining and assured re-employment which would instill confidence and maintain morale.

The first government attempt to nationally address the problem was reflected in the Jay Report³² which made sweeping recommendations on the future of the nursing profession in the field of mental handicap. There are currently some 28,500 direct residential staff to care for approximately 60,800 mentally handicapped people in Britain. The Jay Committee recommended the approximate doubling of this number. They also made comprehensive proposals about recruitment, staff training and organisation and management. These proposals were

directed principally to care in the community for which a qualification under the auspices of a social work training body would be required. The sensitivity of staff is reflected in the fact that the proposals were rejected summarily by health unions and professional bodies, while being generally acclaimed by mental handicap organisations.

There is also a more subtle, *albeit* understandable, reason for resistance to government policy. Senior staff—and particularly consultant psychiatrists—have come to regard the institution as representative of their own status and authority. The continuance of the institution is seen as a measure of the psychiatrists' self-worth and of the value of the medical profession itself in the field of mental handicap. Colloquially speaking, the practitioner views the hospital with a feeling of "ownership" and "turf", and he has come to protect it accordingly.

The Future

The decision to care for mentally handicapped people in large remote institutions was never taken on the basis of evidence of their effectiveness or feelings for their humanity. Whether examined from a viewpoint of finances or efficacy, the continued operation of large institutions cannot be regarded as a rational government policy. Indeed, even the maintenance of parallel services for mentally handicapped people is uneconomic.

It is ironic, then, that the employment needs and status of professionals, who are fully cognizant of the developmental nature of mental handicap, should pose such formidable obstacles to the success of current government policy. Partly, it is a matter of attitude and of the inevitable preservation of the status quo.

It is the responsibility of government to encourage imaginative approaches to care and habilitation within the community, but, more importantly, the government must develop sensible retraining programmes, assist staff with rehousing and relocation, grant sufficient funding for high quality community facilities, and provide remuneration commensurate with the value of the care provided by staff.

The legacy left by policies of segregation, and the past association with criminality and immorality, leave any government with a heavy responsibility to ensure that mentally handicapped people are integrated into the community and provided with humane care and effective habilitation.

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References and Notes

1. The Mental Health Act (England and Wales) 1959, s.4, defines mental disorder to include subnormality. The government has indicated that this term will be replaced in amended legislation by mental handicap. Department of Health and Social Security, *A Review of the Mental Health Act 1959* (1976); H.M. Government, *Review of the Mental Health Act 1959*, Cmnd. 7320 (1978). See also Gostin, "The Merger of Incompetency and Certification: The Illustration of Unauthorised Medical Contact in the Psychiatric Context," 2 *Int'l J. Law and Psychiatry* 127-130 (1979). Mental deficiency used to be the statutory term in England and Wales and still is in Scotland. Mental retardation is used in the United States and by the World Health Organization. The term mental handicap is used in this article because it emphasizes that cognitive and social deficits are human disabilities which should not be viewed as a condition wholly separate and apart from other handicapping conditions. Social policy in respect of any physical or mental disability should be to prevent it whenever possible, to do everything possible to alleviate its severity and compensate for its effects and to reduce physical and social barriers which impede full integration of handicapped people into ordinary community life.
2. For an examination of the constitutional issues and difficulty of judicial enforcement of the rights of mentally retarded people in the community, see Gostin, "Current Legal Concepts on Mental Retardation in the United States: Emerging Constitutional Issues," in Tredgold's, *Mental Retardation* 294 (Craft, M., ed., 12th ed., 1979).
3. It is the Secretary of State's duty under section 3 of the National Health Service Act 1977 to meet all reasonable requirements for the prevention, care and after-care of persons suffering from physical or mental illness.
4. The Housing Act 1957 requires local housing departments to meet needs for housing in their areas and, under the Housing Act 1974, they must provide a range of housing including single dwellings, bed sitters and hostels. The Housing (Homeless Persons) Act 1977 imposes a duty on housing departments to provide accommodation for homeless people with priority need. For a fuller examination of housing legislation referable to mentally handicapped people, see Gostin, "The Law Relating to Mental Handicap in England and Wales," in Tredgold's, *Mental Retardation* 271, 278-80 (Craft, M., ed., 12th ed., 1979).
5. The Education Act 1944 requires every local education authority to provide full-time education for children aged five to 17 which is suited to their different ages, abilities and aptitudes. An additional duty is imposed to provide education by special methods appropriate for persons suffering from a mental or physical handicap. The Department of Education and Science issued a circular 15/70 which stated that "no child within the age limits for education . . . will be outside the scope of the educational system." Section 10 of the Education Act 1976 establishes the principle that special education must be provided in ordinary schools unless it is "impracticable", "incompatible with the provision of efficient instruction in the schools", or "would involve unreasonable public expenditure". The provision will not come into effect until a directive is given by the Secretary of State. See generally, Gostin, "The Right of a Mentally Handicapped Child to Receive Education," *Disability Rights Handbook for 1979: A Guide to Income Benefits and Services* 45 (1978). On the issue of education of mentally handicapped children in ordinary schools see, *Special Education Needs - Report of the Committee of Enquiry into the Education of Handicapped Children and Young People* (The Warnock Committee), Cmnd. 7212 (1978).
6. See generally, *Disability Rights Handbook for 1981: A Guide to Income Benefits and Services* (1980).
7. See e.g. Housing (Homeless Persons) Act 1977 which designates mentally handicapped people and their families as a priority for the provision of housing.
8. See L. Gostin and E. Rassaby, *Representing the Mentally Ill and Handicapped* (in press).
9. Dendy Homes, appendix in C.P. Lapage, *Feeble-Mindedness in Children of School Age* (1920).
10. See K. Jones, *A History of the Mental Health Services* 183-85.
11. Lewis, appendix in *Report of Joint Committee on Mental Deficiency* (Wood Committee) (1929).
12. The development of categorisations and definitions of mental handicap in English legislation leading to the reform of the Mental Health Act in the 1980's is illuminating in its own right and will be the subject of a separate article in a following issue of *Amicus*.
13. The Royal Commission on the Care of the Feeble-Minded (Radnor Commission) (1908).
14. Hansard, 15 April 1943.
15. *A Report on the Future Organisation of the Psychiatric Services* (1945).
16. *The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*.
17. See generally, Gostin, "The Merger of Incompetency and Certification: The Illustration of Unauthorised Medical Contact in the Psychiatric Context," 2 *Int'l. J. Law and Psychiatry* 127-130 (1979).
18. Department of Health and Social Security and Welsh Office, *Better Services for the Mentally Handicapped*, Cmnd. 4683 (1971). (A White Paper is a statement of government policy.)
19. E.g., Department of Health and Social Security, *In-patient statistics from the mental health enquiry for England, 1975*. Statistical and Research Report Series No. 17 (1978).
20. Department of Health and Social Security, *Priorities for Health and Personal Social Services in England: A Consultative Document* (1976).
21. E.g., National Development Team for the Mentally Handicapped, *First Report: 1976-77* (1978); National Development Team for the Mentally Handicapped, *Second Report: 1978-79* (1980). See also National Development Group for the Mentally Handicapped, *Mentally Handicapped Children: A Plan for Action* (Pamphlet number 2, 1977).
22. *The Report on Child Health Services: "Fit for the Future"* (The Court Committee), Cmnd. 6684 (1976).
23. M. Oswin, *Children Living in Long-Stay Hospitals*, Research Monograph No. 5 (Spastics Int'l.) (1978).
24. These examples are from first hand observations in mental handicap hospitals. See also, *MIND's Evidence to the Royal Commission on the NHS With Regard to Services for Mentally Handicapped People* (1977).
25. See generally, Herr and Gostin, "'Volunteering' handicapped children for institutions - a case for review." XXVII *Oxford Medical School Gazette* 86 (1975).
26. Gath A., *Should retarded children be kept at home?* Unpublished paper read to the Association for Child Psychology and Psychiatry; Bayley, M., *Mental Handicap and Community Care: A Study of Mentally Handicapped People in Sheffield* (1973).
27. Shearer, A., *Fostering Mentally Handicapped Children* (1974); Dr. Bernardo's N.W. Division, *A Project to Assist Families with Mentally Handicapped Children in Chorley and District* (1974).
28. Kushlick, *The Mentally Handicapped*, in *Positions, Movements and Directions in Health Services Research* (Nuffield Provincial Hospitals Trust, 1974).
29. Department of Health and Social Security (DHSS), *Report of the Committee of Inquiry into Allegations of Ill Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff*, Cmnd. No. 3975 (1969); DHSS, *Report of the Committee of Inquiry into South Ockenden Hospital* (1974); DHSS, *Report of the Farleigh Hospital Committee of Inquiry*, Cmnd. 4557 (1971); DHSS, *Report of the Committee of Inquiry into Normansfield Hospital*, Cmnd. 7357 (1978).
30. National Development Group (NDG), *Helping Mentally Handicapped People in Hospital*, chapters 5 and 6 (1978), reproduced as NDG, *Creating a Learning Environment* (1978).
31. *Report of the Royal Commission on the National Health Service*, para. 10.60, Cmnd. 7615 (1979).
32. *The Report of the Committee of Inquiry into Mental Handicap Nursing and Care* (1979).