Employment of mentally handicapped people

A RECENTLY published report of the proceedings of a two-day workshop held at the King's Fund Centre on 11 and 12 December 1974, entitled *Employment of Mentally Handicapped People,* makes fascinating reading, and should prove helpful to all those concerned with the well-being of handicapped people and those interested in helping them to realize their potential.

The two-day multidisciplinary workshop expressed concern at the low level of successful employment attained by the mentally handicapped, and aimed to examine the facts, to share the experiences of those involved with training, placing and employing such clients, to find out what can be achieved, and to identify difficulties and consider ways of overcoming them.

About 8,000 trainees—those mentally subnormal to any degree—in England and Wales are thought capable of open employment, providing there are enough places, while others are held back because of low expectations of staff and lack of specific work training.

In fact, only small percentages of trainees, from 5·4 per cent down, were in open employment in different parts of the country. Only 12 per cent of adult training centres (ATCs) reported that sheltered work places were available for trainees. If government agencies like Remploy take only a tiny percentage, any official criticism of industry, which is not nearly as well-informed on trainees' capabilities as Remploy, should be muffled. Indeed, the Department of Employment's policy of allocating only a small percentage of places to 'mentally disordered' people reflects the misguidedly low expectation of their ability, both in sheltered and open employment. Actually, the figures show that it is about ten times more difficult for a trainee to get a sheltered workshop place than it is for him to obtain a place in open employment—which says a great deal more for private employers than statutory agencies.

Of the 120,000 severely mentally handicapped in England and Wales, about 50,000 are children. Many more are only slightly handicapped.

A demonstration project involving a typical group of trainees from adult training centres has shown that, even with a very short period of training, they can complete a complex assembly task well within the time allowed for the semi-skilled fitter in the factory. Such demonstrations are invaluable since low staff expectations lead to low levels of achievement. Untrained staff harbour the most pessimistic expectations, whilst staff in training have the highest. Trained staff expectations fall between the two, underlining the importance of basic and continuing education, and more opportunities to develop specialist skills.

The Education (Handicapped Children) Act 1970 made the education of handicapped children the responsibility of local education authorities instead of local health authorities, who, until the late fifties and early sixties, when junior training centres began to be built on a significant scale, did little by way of training, social care, or support.

More recently there has been the emergence of the National Development Group for the Mentally Handicapped. Now more planners, practitioners, parents, administrators and volunteers are working, more or less together, towards more hopeful goals. But even progress produces its own anxieties, typified by the title of a recent conference in Liverpool: 'Rehabilitation—For What?' It is fundamental that any improvement in education for mentally handicapped children and adolescents should be matched by a progressive pattern of services for them as adults. Otherwise all will be waste, frustration, and disillusionment. Even the staff of adult training centres tend to underestimate trainees' abilities and potentialities, and all too often placement is seen as a single step, rather than as one of a number of steps in a carefully planned process of integrating the mentally handicapped person into society.

All the evidence shows that economic rather than humanitarian arguments are the more persuasive in helping to train, employ, and integrate subnormal trainees in society.

Local authority performance varies widely, owing not to any marked difference in the incidence of mental handicap, but rather to the degree of willingness to provide facilities.

There is much evidence too that many trainees in training centres could hold jobs in normal situations given the chance, while others could make the transition via sheltered employment, were there enough human resources to inculcate the necessary levels of self-sufficiency.

Time and again there is reference to the excessively low expectation of trainees' capacities among hospital and training centre staff, proving yet again how history continues to take its toll by bequeathing prejudices and distorted evaluations, be they medical, social, or technical.

The two-day workshop came to these conclusions:

1. Low expectations

We expect too little of the severely handicapped. Their capabilities are viewed too pessimistically by many staff, and therefore by the public at large.

2. Inadequate training

Training in work skills is not good enough. Not all staff are sufficiently aware of how much more could be achieved by the mentally handicapped, given better training. Targets are too low; assessment is frequently absent or inappropriate, and detailed programming is rare.

3. Doubts about role

Adult training centres are unsure of their purpose. Many have to cope with several roles, education and training sometimes taking second place to custody and occupation.

4. Inadequate staffing

The staff structure of training centres is inadequate. Many centres have inadequate staff ratios, insufficient relief staff, and ill-defined career paths. Hours and conditions of service vary widely.

5. Difficulty in finding work

Work is very hard to find. For those severely mentally handicapped people who receive proper training, sheltered workshops are too selective, vocational counsellors are rare, and employers are hesitant.

6. Need for Government action

A Government lead is vital. At the moment there is a lack of a clear lead from Government departments and agencies. Departmental initiatives tend to be uncertain and there is no active promotion of the right of mentally handicapped people to work. Departments such as Health and Social Security, Education and Science, Employment, and Environment should be making joint efforts, and statutory and voluntary agencies need to combine to improve adult centre programmes, to modernize the staff training system, to set up a job placement service, to make sheltered work less selective, to make open employment more open, and to affirm the civic right of the mentally handicapped person who is able to work to do so for proper pay.

A need to differentiate between the three functions currently undertaken by the ATCs—day care, training, and work—was also expressed and there was a call to give special encouragement to research likely to produce results which can be applied by service providers after the departure of the specialist researchers.

Much remains to be done to integrate and realize the potentialities of the mentally handicapped in society, but progress has been made in knowledgeable climates, professional and social, since the years of the 'village idiot' and the mass incarceration of the mentally defective in various poor law institutions. Medical science has had much to do with these advances, and now enables physical and other deficiencies to be distinguished from intellectual retardation.

However, social capacity remains the overriding criterion of subnormality, but since it is usually linked with intellectual capacity, it remains important to establish the individual's IQ, whilst providing the most helpful conditions in which his potential may be fully realized.

Reference

King's Fund (1974). *Employment of Mentally Handicapped People.* London: King's Fund.

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Integration of patient care

UNDER the initiative of the Royal College of Physicians of Edinburgh, a working group was set up in April 1974 linking the Royal College of Physicians and Surgeons of Glasgow, the Royal College of General Practitioners, and the Faculty of Community Medicine in Scotland. As a result of these interdisciplinary discussions, working groups were set up to examine four common clinical conditions through which integrated clinical care could be improved and the most effective use made of available resources. The four conditions chosen were hypertension, stroke, diabetes, and dyspepsia.

The conference received reports from each of the working groups set up throughout Scotland.

Many difficulties had arisen about common definitions for morbidity, aims in treatment, and the acceptance of responsibility by the appropriate clinicians. The practical problems of integrating the community-medicine specialist, the hospital consultant, and the general practitioner were shown to be difficult but nevertheless beginning to yield to the co-operative approach which has been stimulated by the Royal College of Physicians. However, the conference revealed a willingness on the part of all the doctors involved to submit to the discipline of assessment with a view to improving comprehensive care for their patients. The latter point was vividly demonstrated in a formal paper presented by Professor Dollery of the Royal Postgraduate Medical School. He had carried out a study involving general-practice and hospital records of 100 deaths from malignant hypertension in London. He indicated a ready co-operation on the part of both the hospitals and general practices to make their records available for the purpose of audit, and it was comforting for us in general practice, if not for our patients, to learn that the hospitals fared almost as badly as we did in the management of continuing care of patients with severe hypertension.

The conference itself was essentially an educational exercise, showing once again the importance of communication throughout all branches of the health service. The faculty structure of the Royal College of