The Mental Deficiency Services

An Analysis of Existing Policy and the Community's Requirements

A Report by the Mental Deficiency Sub-Committee, British Medical Association (New Zealand Branch)

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FOREWORD

By Sir Charles Burns

In this age of scientific progress, when interested persons are looking for fresh fields to conquer, it is little wonder that there should be those who have dared to shine the torch of modern knowledge and modern skills lit by the hand of human hope into the dark, dank "stagnant pool" of mental subnormality, that to our shame has been so long neglected.

The number of those afflicted in this way is too great not to constitute a challenge to their parents, to the professions of medicine and of education and to the public at large. It was in the hope of doing their part to meet this challenge that the "Intellectually Handicapped Children's Parents' Association" petitioned Parliament in 1950 in the hope of obtaining better facilities in this country for their afflicted ones. As a result a Consultative Committee was set up under the chairmanship of the then Vice-Chancellor of the University of Otago, Dr. R. S. Aitken, some time Professor of Medicine in the University of Aberdeen, and therefore interested in both the educational and the medical aspects of the problem. Associated with him on this committee were senior personnel from the Divisions of Child Health and Mental Hygiene of the Health Department and from the Education Department, includng its Supervisor of Psychological Services. The subsequent report was based on evidence obtained from very many interested associations and persons, and its findings, concise and succinct, would seem to have answered to the best of the knowledge acquired by it, the questions put by the I.H.C.P. Association.

Nevertheless it failed in its purpose, which was surely to recommend ways and means of improving the lot of the mentally subnormal child and it failed seemingly because it took no cognisance of what was going on in the world elsewhere. Indeed it cannot but astonish the reader to find that the only overseas publication listed in this report is that of the Mental Deficiency Committee, London, 1929.

The Aitken Report itself was submitted to the Minister of Education in December 1952, and published the following year. In February 1953, there was set up at Geneva a World Health Organisation Expert Committee, of similar composition, under the chairmanship of Dr. L. T. Hilliard, Physician Superintendent of the Fountain Hospital, London, a man whose name is a household word in this specialised field of psychiatry. He was ably supported in his deliberations by educationists, psychiatrists, and psychologists drawn from Europe generally including Great Britain, and from the U.S.A. Their committee was known as the Joint Expert Committee on the Mentally Subnormal Child. Its report was first published in November 1953, and has been reprinted thrice since.

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To anyone who has read these two reports it must come as no surprise that those interested in the mentally subnormal child should be gravely concerned to find that those in authority in this country and responsible for the planning for these children, should seem determined to pursue the policy recommended in the Aitken report when these recommendations are based on outworn and outmoded ideas. Surely it is not too much in the face of the findings of a committee of later date, and supplied with the very latest knowledge, to say that it was only proper to scrap the findings of our own consultative committee, or at any rate relegate it as a practical working tool to the archives of the Department whence it emanated.

It was in the hope of influencing in the first instance the general body of their own profession, and through them all other interested professions, departments, associations and persons, that certain members of the British Medical Association asked for permission to set up the committee responsible for the report which is herewith submitted. It is their hope, in particular, that there will be a halt in the building of large institutions for the mentally subnormal far removed from the homes of their parents, in favour of smaller units in the neighbourhood of urban areas, easy of access to those concerned, and that everything possible will be done to further their education. For it has been shown that for all but the most severely afflicted far, far more can be done in this direction than seemed in former days to be possible.

It is with great satisfaction that I acknowledge the enthusiasm, the hard work and the care that has been put into this report by the representatives on the committee stationed in Dunedin, without whose continuous co-operation it could never have been produced; besides reviewing present conditions in New Zealand as they have observed them, reference has been made to some thirty-eight authorities in the fields of psychiatry, education, psychology and social services generally. Many of these references are actual personal communications from the authorities quoted, and to these persons we are also indebted.

Having accepted the chairmanship of this committee with little knowledge of the subject over and above that of the average general physician, it has been a revelation to me to find what real advances have taken place in the subject in recent years and I am now of the firm opinion that the recommendations in this report are such that they should receive most serious consideration from all the authorities concerned. This country has in the past boasted of being in the forefront of social legislation—must it now look with closed eyes at the prospect of complete misdirection in this field of social endeavour, affecting persons utterly dependent on those around them to whom they have a right to look for charity in the fullest meaning of the word? They may have been given but "half a talent" to work with, but they are entitled to the opportunity of improving on even this little.

Introduction

Medical and other sociological practices in mental deficiency are changing fast. For this reason, the tasks of this British Medical Association Sub-Committee—to appraise official policy and the expenditure planned for the mental deficiency services—necessarily include a survey first of current trends and new perspectives in this field. This provides the essential background by which to assess existing facilities and the proposals announced for their expansion, and to indicate the developments a community service requires.

Accordingly, *this Report is framed in six sections*—

I. *Modern Practice in Mental Deficiency* (Subsections 1 to 10): a conspectus of contemporary opinions and developments, and of the kind of social services generally desired nowadays.

II. *Existing Mental Deficiency Services in New Zealand* (Subsections 11 to 13): a brief and factual description.

III. *Shortcomings in the Existing Services* (Subsections 14 to 22): an analysis in the light of section I, of the inadequacies of the present provisions as outlined in section II, and of the reconstruction and new facilities required.

IV. *Appraisal of Official Policy* (Subsections 23 to 26): the considered views of the Subcommittee on Government policy (so far as it has been announced), with particular reference to the institution-building programme, and to the Aitken Report[1] which is known to be the basis of this policy.

V. *Outline of a Community Service.*

VI. *Summary and Recommendations.*

I. Modern Practice in Mental Deficiency

1. *The Use of the Term "Mental Deficiency" as a Diagnosis*

Mental defect is the end-product of a multitude of diseases which share certain therapeutic needs but otherwise differ widely in nature. It is thus a symptom and not a disease sui generis, a fact ignored in the legal and colloquial usages of the phrase, "mental deficiency". As a designation, it can conveniently be used for the general subject of intellectual subnormality, but as a medical diagnosis, the term is inadequate. Even more so is its common variant in mental hospital use, "C.M.D." (congenital mental deficiency), which wrongly implies that these conditions are always congenital and which therefore is improper and well overdue for discard.

2. *Distinction of the Physiologically Subnormal (Dullards) from the Pathologically Defective (Aments)*

For practical purposes, there are two types of individual who come to clinical attention on account of backwardness—the "dullard" and the "ament". We recommend that these terms be generally adopted to refer to the present level of function in these cases and that they replace the pre-scientific gradings into idiot, imbecile, and feeble-minded, customary hitherto.

Briefly, the relevant considerations are as follows[2]. The range of intelligence found among "defectives" in institutions remarkably overlaps that in the normal community outside.[3, 4, 5] Test scores in the latter lie smoothly and symmetrically on either side of a mean, along a Gaussian curve[6], and the lower reaches of this curve[7] (I.Q.'s of 50 to 70) will comfortably accommodate a segment of institutionalised "defectives" as well as some 2¼ per cent of the normal population. Thus in this stratum, intelligence, if subnormal, is not pathologically so, since it is compatible with day to day life in society. It follows that intellectual limitations alone do not account for a proportion of "defectives" being under care, for they do not differ so far as that is concerned from many ordinary folk. Their failure to survive independently arises through insufficiency not of intelligence but of other psychological functions. In respect of intelligence, they are physiologically subnormal and no more.

To apply the terms "feeble-minded", "moron", or "mental defective" to these people deceptively focusses attention on their intellect (implying pathology where none exists) and distracts it from other more crucial handicaps (where pathology waits for diagnosis and treatment). We therefore advise discarding such terms as misleading and referring to these cases as "dullards".

The term "dullard", with its implication of physiological subnormality of intelligence, usefully distinguishes a large category of persons treated administratively as defective, from the remainder whose intelligence is so deviant as truly to fall below the range of normal variation. These latter we propose to designate as "aments", a term implying pathological defect of intelligence.

This distinction between "dullards" and "aments" is stressed because their clinical management and its goals are not the same. The traditional classification of defectives into idiots, imbeciles, and feeble-minded serves no purpose, confuses pathological with physiological, and is also being discarded in other countries[8, 9].

3. *The Likely Incidence of Dullards and Aments in New Zealand*

Assuming the population (2.275 million) of this country resembles other European ones, it must contain some 6,800 aments (the great majority of whom are trainable up to some point)[10] and about 50,000 dullards—according to the best accepted opinion, 0.3 per cent and 2.26 per cent respectively[11]. The number of imbeciles and idiots, 4,000, that is estimated in the Aitken Report[1] is therefore far too low.

It may be observed here that with only some 10,500 beds in mental hospitals, it is unrealistic to suppose that in any foreseeable future institutional care can be the standard answer for the problems of mental defect. These figures alone are a weighty reason, among others that follow, for the development of extramural services.

4. *Capacities of Dullards and Aments*

Recent years have seen an awakening of inquiry into the abilities of people of low intelligence and a growing recognition that these exceed the pessimistic preconceived estimates entertained hitherto.

(a) *Dullards.*—Most dullards inconspicuously form 2½ per cent of the population and earn their own living. It should seldom be necessary for any to require more than short term institutional care, and failure in their rehabilitation is rarely unavoidable.

Over many years, at the Fountain Hospital in London, Hilliard[12] has shown that even with most unfavourable cases—a series of rejects from other institutions, where they had spent an average of twenty years—nearly all dullards can be found lasting employment at trade union terms in the community. This was despite initial I.Q's of 34 to 73. His experience is that about 75 per cent of *chronically* institutionalised dullards can ultimately be discharged and that they will save money, marry, and have healthy children[13]. The prominent feature of Hilliard's regime is warm personal interest, informality, and lack of restrictions within and without the institution. Of the first hundred women sent out to a job, only one became pregnant while on licence, despite a previous history of pregnancy in thirty.

At Monyhull, another ordinary mental deficiency hospital in Britain, Gunzburg[14] describes similar findings with a series of 148 youths. Although one fifth had I.Q's under 50, and over half had been before the courts, the great majority were fully rehabilitated and rejoined the community.

(b) *Aments.*—Given industrial tasks—such as assembling bicycle pumps, or soldering eight-pin television plugs—aments can achieve competitive rates of output[15]. While their initial ability may be exceedingly low, their final level is distinguished only by the extra time required to reach it. Furthermore, they respond to incentives, such as verbal encouragement, competition, targets to surpass, with the usual intense acceleration of learning that these will stimulate in normal people[16, 17]. The industrial potential of aments is considered in Subsection 5.

5. *The Rehabilitation and Training of Dullards and Aments*

(a) *Education in Childhood.*—There is widespread accord now that educational programmes instituted in childhood are not only valuable but essential. In 1953, an unselected survey of 51 public residential institutions in mental deficiency in the U.S.A. showed[18] that already by that time, 45 (or 90 per cent) were operating formal education schemes for their children. It was the general opinion that there should be "complete educational opportunities from nursery school to continuation school" with "training in leisure-time activities". This is in vivid contrast to the Aitken Report published here in the same year, in which remedial approaches are viewed bleakly[1].

In 1956, the British Ministry of Education advised[19] its local authorities to plan special educational measures for backwardness for about 10 per cent of registered pupils. It enumerated that some 8-9 per cent of these needed extra facilities in ordinary schools, one per cent needed more special education in day schools set aside for the purpose, and 0.2 per cent needed boarding school provision. As will emerge in section III (subsections 16, 17), special educational facilities in this country fall much below these in their extent.

A model education programme along newer lines is operated by the public health department of Monmouthshire, in Wales[20]. The principal finding of this team is that 80 per cent of defective children are teachable, provided that teaching begins early, at two years, and is continued until the age of eighten years. By this it is meant that 80 per cent will reach "artisan" standard, as they call it, namely, acceptable social conduct, gainful work, and useful leisure activity. Since an early start is vital, the scheme includes a clinic for the detection of cases and for arranging preschool training at home, as well as a basic nursery class, a basic junior class, an advanced junior class, a classroom, and senior groups for each sex with vocational training.

In residential institutions, such schooling is no less necessary and as already remarked, formal education was already to be found in 90 per cent of U.S. institutions five years ago. These include projects along lines similar to the Monmouthshire scheme—for example, at the South Wisconsin Colony[21], a syllabus introduced for children with I.Q's of 30 to 50, within six months had brought visible benefits in cleanliness, deportment, speech, and nursing requirements.

A full account of the training school in the intramural setting is to be found in an authoritative British textbook[22]. Its instructions are based on many years of experience with a hospital school manned by a sizeable staff of full-time, specially trained teachers.

It is our view that teaching programmes, both in the community and inside institutions, must be organised and directed by educationists to whose profession it belongs. This is not a province for amateurs, and the medical profession are amateurs in this field.

(b) *Industrial Training in Adulthood.*—"The pessimistic outlook of the past, based as it was upon unrealistic and inadequate training methods, often against a background of national unemployment, is not justified when better training is adopted"[23].

The successful rehabilitation of dullards, even those chronically institutionalised, was referred to above in subsection 4a and is fully explained in the textbook mentioned[22]. The feasibility of training aments for productive work has also been established now. For example, at the Manor Hospital, England, half a dozen unsupervised aments for years, have been turning out 30-40,000 cardboard boxes per 35 hour week; their health is enhanced and their enjoyment obvious[24].

Sheltered workshops both within and without institutions are now beyond the stage of experimental trial; details of their organisation and their importance for rehabilitation may be found in sources quoted before[22, 24]. An instance of such a workshop within a residential institution is that at the South Wisconsin Colony[25]. There, patients with an average I.Q. of 45 (and extending down to 30) are engaged on work under contract from local industry. Jobs undertaken include seven-process tasks, assembly of display kits, filling and packing of wax-tubes, with an output reaching thousands after a few days' practice.

An instance of a sheltered workshop serving extramural patients is Rutland Lodge[26], in Leeds. This is a municipal centre, constructed by converting a big house near the city, and attended by 120 youths each day. Work is taken in from local firms, chiefly die cast assembly and fettling of weighing machine parts. Some 45 different components are now being handled and in 1957, a dozen individuals had an output of 425,000 assemblies. The parents are delighted at their sons' progress since none previously had been thought at all employable. Records are kept for each individual on the relation of wages to output and the incentive effect is enlightening. Like every other human being, the mentally retarded person cherishes some independence, some personal property, some freedom of choice, and he can achieve all this through the opportunity to earn money of his own.

(c) *The Role of Extramural Services in Training and Rehabilitation.*—The supervising social worker, smoothing the patient's relationships, helping him surmount initial difficulties, assisting him to form new social patterns, is all important (also see subsection 10).

6. *The Difficulty of Prognosis of Mental Defect, Especially in Childhood*

Mental deficiency is still commonly looked upon by less informed persons as a static and frozen condition. This is no longer a valid attitude and there is no ground for regarding intelligence as an unalterable endowment, even in adults. Some aments of mature years may be trained into social viability, and nearly all dullards who need help can be fully rehabilitated. Illustrative details are given in subsection 7.

The prediction of future intellectual performance, particularly in a child, should therefore be tentative. Without skilled I.Q. measurement, a clinical diagnosis of mental defect seldom has any exact prognostic meaning, and even with it, there can only be a fluid prognosis (except in the rare instance of the severest ament). For example, Charles[27] observed that of 206 adults who had been ascertained in childhood as defective, 83 per cent had become self-supporting, some even occupying managerial positions, and 65 per cent had children (whose mean I.Q. was 95); Collman and Newlyn[28] followed up 223 defective children (with a mean I.Q. of 61) from special residential and day schools and found that 72 per cent were satisfactorily employed and only 12 per cent were really unemployable—of 14 with I.Q's of 40 to 50, 8 were self-supporting—and they considered that failure in employment was more a result of other handicaps than of lack of intelligence by itself.

While an assessment of the I.Q. by a trained psychologist is certainly a big advance on clinical guesswork, it is only approximately predictive of

future capacity. The I.Q. is far from immutable, particularly at levels of intelligence that are so removed from the mean. Even at normal levels, longitudinal studies show that up to the age of two, test results bear little relation to scores to be obtained later at school[29], that during childhood and adolescence, the I.Q. only gradually becomes steady[30], and that between six and eighteen years, 60 per cent of a repeatedly tested group change 15 points or more on the Binet Scale, and 10 per cent change 30 points or more[31].

Equally large swings are common in aments and dullards and sometimes they make a leap out of both these categories. In certified defectives observed over two years, at the Manor Hospital, England, rises of up to 25 points were found, particularly in young people coming from bad homes[32]. The occurrence of such changes in adult cases is not only more frequent than is often supposed, but is also significantly augmented in patients exposed to a rehabilitation programme when compared to controls not so treated[33].

Consequently, a confident prognosis in childhood, especially in early childhood, of the adult level of intelligence and social adaptibility is seldom scientifically justifiable. Completely hopeless aments are the exception, and in fact, most backward children are either dullards (who should become self-supporting in time) or borderline aments (and grading as an ament now need not mean grading as an ament in the future).

This uncertainty of prognosis indicates that extreme caution, repeated observation, and expert experience must surround any decision to place a child in an institution (the dangers of institutionalisation are considered below in subsection 5). Furthermore, it implies that permanent, hard and fast arrangements are to be avoided if institutional care does enter.

We therefore recommend that elaborate psychological and pædiatric investigation be mandatory before admission of a child as mentally defective to an institution. Also, regular and frequent reassessment likewise should be mandatory. We do not regard isolated intelligence tests, especially when performed by untrained testers (most medical men are in this category), as fulfilling the requirement here of psychological assessment.

It is our view that the present procedure for admission involving certification by two medical practitioners, on the basis of a single examination of the patient, is entirely unsuitable and inadequate for the purposes outlined. Few practitioners are capable of or instructed in psychological assessments; even if they were more so, the existing ritual would remain hazardously inappropriate and limited.

We reject recommendation number 4 in the Aitken Report[1] to the effect that parents be encouraged to place the intellectually handicapped child in institutions at the age of five. The statement that "he is never going to face the complicated adult world unprotected and relying on his own resources" is an assertion unrelated to scientific studies (see below, subsections 23b, 24b). The practitioner who, as a rule, can unhesitatingly inform the parents of five year olds of such a future is using prophecy rather than prognosis. While admission at the age of five may be correct in a few cases, as a general recommendation it becomes even less tenable when the disquieting proportion of dullards among children entering our institutions is noted (see subsections 19 and 20).

7. *The Dangers of Institutionalisation*

From subsections 4, 5, and 6, it emerges that the adult level of intelligence is not mechanically pre-set and its growth fluctuates—some influences depressing, others perhaps promoting it. Noxious influences include an unfavourable social environment[34] and therefore, in addition to the well-known psychological

risks incurred by separating the child from its family[35], placing it in an institution may blight its intellectual development[36, 37]. The earlier this is done, the greater is that risk and the less the justification for taking it, since any assessment of intelligence decreases in reliability, the younger the subject.

By institutionalising youngsters, a normal child may be pushed down to a dullard level or worse, and a dull child converted to an ament. Hilliard[12] has remarked that, with mental deficiency, "too often the diagnosis creates the disease", and certainly an infant placed in an institution and who never learns to speak, may simply have lacked enough opportunity to hear normal conversation. Kirman[38] points out that in a residential nursery for *normal* children under three, new arrivals who could speak soon ceased to do so. He emphasises the danger of a potentially educable child being rendered ineducable through mistaken and premature admission and he adds that the decision to place a child in an institution on account of mental defect is *almost never* taken in the interest of the child itself.

We therefore recommend that to prevent too early institutional care (for which we find evidence in subsection 20) and its attendant perils, various measures be employed, including the payment of extra child allowances to the mother, the encouragement of foster-home care by proper and realistic payment of foster mothers, and the development of community services to be outlined.

8. *The Modern Shift of Emphasis from Institutional Care to Community Services*

Since the war, there has been a world wide growth of emphasis on extramural services for the mentally ill and the mentally handicapped *in general,* and a corresponding reduction in favour for institutional treatment. The British Royal Commission[39] has forcefully reiterated this. "In relation to almost all forms of mental disorder, there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital, or which make it possible to discharge them from hospital sooner than was usual in the past." Furthermore, it underlined that residential treatment, when it was necessary, should be planned on entirely new principles. "We are convinced that the aim should be a deliberate reorientation, away from institutional care in its present form and towards residential homes in the community . . . in our views, many of the patients at present in mental deficiency hospitals would be more suitably accommodated in such homes".

The same theme is to be found in the World Health Organisation's Expert Subcommittee's Report on the Mentally Subnormal Child[40]. "Fortunately, it is not often necessary to take children from their homes and, with adequate economic aid to parents, skilled social case-work, and properly organised and comprehensive social services, it will become less so . . . As a general rule, home care is to be recommended . . . generous financial and practical assistance to parents is still cheaper than hospital care, a point not often realised."

For mentally handicapped persons of all kinds, the movement away from long term (residential) treatment in the traditional type of institution is so extreme that the President of the American Psychiatric Association has publicly advised state governments that *all* mental hospital building should cease forthwith[41].

9. *The Modern Residential Institution: Its Structure and Function*

The contemporary style of residential institution is "a flowing lake as opposed to a stagnant pool." Its aim is to serve three functions,

(a) short stay care which is geared to rehabilitation,

(b) brief care of patients when their families are on holiday or need relief during illness and other crises,

(c) long term care with training for that proportion of aments who prove unfit for life at home, or whose home cannot support them.

For these purposes, the residential centre must be organised with certain facilities and along certain principles. *For adults, the requirement is a hostel atmosphere, for children that of a residential school;* the structure must therefore consist of family type units in *small* institutions, and the setting must be in close relation to the general community towards which rehabilitation is directed. All these points are heavily supported by modern authority (subsections 21, 25, 26) whose opinions we shall quote when we consider the shortcomings of the present policy for the mental deficiency services in section III and IV below and the need for provision of local hostel accommodation rather than of enlarged institutions.

In the case of persons who require long-term care, the institution should serve to relieve the family of their burden but not to relieve them of their child. This reinforces the need for scattered, residential centres easy of access, and for admission to be informal, easily arranged (with beds specially set aside for the purpose) during illness, family holidays and crises, and free of present legalities. "In some countries, there are complicated procedures requiring a judicial order before a child can ever be admitted to a hospital for the subnormal. And once a child is admitted, the parents may lose all control over him. This antiquated procedure is quite unnecessary in the case of children or of those who suffer from fairly severe subnormality. It is also highly offensive to parents"[42].

For severely backward children, learning is achieved by doing, and instruction confined to classroom periods alone is useless. The basic skills of normal life are lost if there is none of the normal setting for practising them continually. It amounts to psychological malnutrition to place healthy children in wards of 30 or more, especially when set in institutions for several hundred, and it is all the more contraindicated for children who are mentally handicapped. Recommendation number 2 in the Aitken Report[1], which advises this measure, is therefore unacceptable, as is also its incorporation in official policy (subsections 23 and 26).

For training and rehabilitation to be achieved, as described in subsection 5, the residential centre must supply, or have local access to special educational facilities, remedial specialists (including speech- and physio-therapists), occupational instruction, and sheltered workshops. Furthermore, rehabilitation and successful discharge will depend on thorough integration (administratively, and through social workers, vocational guidance officers, outpatient clinics) with the ordinary community and its social and medical agencies, its industry, its voluntary bodies, and its extramural provisions for the mentally retarded.

10. *Extramural Services in the Community Setting*

The development of facilities for the non-residential training and care of the ament and dullard is a conspicuous modern advance that already far outweighs institutional care in some countries (see subsection 14). That is the case in Britain. The Royal Commission reports[43]: "In the past, treatment was mainly institutional but now a great deal of medical treatment and social care is given to mentally ill and mentally defective patients while they continue to live and work in the general community. Care and training are

provided for many more defectives (children and adults) through community mental health services than in hospitals. . ." Even so, the Royal Commission still considered that this reorientation had not gone far enough (see subsection 8).

An extramural mental deficiency service includes the following facilities:

(a) *Mental Deficiency Clinics*[44,45,46,47,48] are arranged to supply two main functions that may be briefly explained here. The first is early detection of cases, their psychological assessment, and their prompt introduction to suitable educational programmes and to remedial treatments organised both in the clinic and at home. The second is guidance and counselling for the parents of retarded children.

Casework[49,50,51,52] with parents is now an established routine for psychiatric social workers based on a mental deficiency clinic in the locality. For the parents of a child who is handicapped (mentally or otherwise), to issue a diagnosis and a set of instructions is not enough. Their problems and difficulties are inevitably complex and emotional, calling for individual understanding and trained insight—more, that is, than plain advice. Periodic and regular acess to specialist attention and support must be available as otherwise there is a trail into medical shopping expeditions, from doctor to doctor, and false hope to false hope.

In summary, the overall purpose of the clinic is to supervise the welfare and observe the progress of the ament and young dullard especially. By providing diagnosis and assessment, parent guidance, out-patient and domiciliary treatment, and supervising social case-workers, and by acting in concert with other extramural facilities, with general practitioners, and with residential centres, it is one of the hubs of a community mental deficiency service.

(b) *Special Education, and Vocational Training Programmes* (see subsection 5).

(c) *Sheltered Employment and Sheltered Workshops* (see subsection 5).

(d) *Psychiatric Social Workers* supervise home and industrial adjustment (especially important for ensuring the success of rehabilitation) and integrate other services with employers, trade unions, voluntary bodies.

(e) *Foster Home Care*: An ancient device for the long-term care of the mentally handicapped is the foster home. It is the custom, since the middle ages, in certain towns and villages in Europe, for the inhabitants to board and look after such persons, and a practice recently reinvestigated. "Family care placement"[53] has been studied over ten years at the Lapeer State Training School, 247 patients, mostly with I.Q's under 50, being lodged with volunteer families in the vicinity. In over two thirds, placement proved lasting and satisfactory and of those who returned to the institution, less than half were required to do so on account of any unacceptable behaviour.

The foster home is not only a necessary alternative to institutional care where that may be contraindicated (subsection 7) but it may also be a feasible one in a proportion of cases who are too helpless to be managed in their own families. It is an old avenue to be explored afresh.

We would recommend the establishment of a register of suitable foster homes.

(f) *Parent and Family Organisations*—self-help and group work by volunteer bodies is an indispensible aid to mental health services. We warmly recommend the constructive aims of the Intellectually Handicapped Children's Parents' Association which parallels similar societies overseas.

II. Existing Mental Deficiency Services in New Zealand

The sources for the information in this survey are,

(1) a return reporting to Parliament on Intellectually Handicapped Children, signed by the Minister of Health, October 1957.

(2) a letter from the Director, Division of Mental Hygiene, Department of Health, July 4, 1958.

(3) a letter from Mr. B. M. Pinder, Senior Inspector of Schools, May 28, 1958.

(4) statements by Ministers of the Crown, October and November, 1957.

11. *Education Department*

The services supplied by the Education Department are as follows:

(a) *Special Classes for Backward Children.*—These are located in ordinary schools. Admission is arranged by six Area Organisers who, with the special class teachers, also assist in work of local After-Care (Special Class) Committees. These are concerned with the occupational and social adjustment of school leavers from these classes. Total roll (August, 1957), 784.

(b) *Residential Schools for Backward Children.*—Otekaike 70, Richmond 52, total roll 122.

(c) *Occupation Centres.*—These are for children not capable of benefiting from education in ordinary schools. The minimum roll is 12; the minimum staffing is two teachers (one teacher to ten pupils). Seven centres are in existence and six more are planned. Total roll (August, 1957), 244.

(d) *Occupation Groups.*—These are subsidised by the Education Department and staffed and organised by the Intellectually Handicapped Children's Parents' Association. They have five to eleven pupils and operate one to ten half days per week. So far, twelve such Groups are in operation. Total roll (August, 1957), 131.

(e) *Correspondence School.*—A special programme for children of Occupation Centre level is offered by the Correspondence School.

(f) *Psychological Services.*—In six centres, the Education Department's Psychological Service offers a "complete diagnosis of the child's handicap."

12. *Health Department*

The services supplied by the Health Department consist of in-patient accommodation under the Mental Hygiene Division and limited out-patient facilities.

(a) *Mental Hygiene Division.*—

	Beds 1957	Planned to be enlarged to total of
Templeton Farm	432	750
Levin Farm	453	750
Nelson	194	
Tamariki Ward, Waitati	22	
Mangere (Auckland)	–	? 750
Orokonui (Seacliff)	–	?
Total in mental deficiency institutions ..	1,101	
Other mental hospitals (8/3/58) ..	1,980	
TOTAL mentally deficient persons under care (as at March 8, 1958) ..	3,081	

The total comprises 248 idiots, 1,667 imbeciles, and 1,166 feeble-minded.

Templeton and Levin each have a Medical Officer, Training Officer, Occupational Therapist, and Nursing Staff. A teacher is employed at Nelson. Priority is given to the admission of children to the special institutions for defectives.

Government policy is to build accommodation for the mentally subnormal separate from the mentally ill.

(b) *Out-patient Facilities.*—Certain out-patient facilities, largely limited to diagnostic advice, so we believe, are provided in the Child Health Clinics (six in number), in pædiatric departments of public hospitals, and at psychiatric clinics in public hospitals (in so far as these are available).

13. *Residential and Other Amenities Supplied by Voluntary Bodies*

(a) *Short Stay Homes.*—Conducted by I.H.C.P.A., these receive a subsidy of up to 50 per cent on approved buildings and hard furniture and 6/- per day per patient until the age of 16 years.

Residence is limited to two months but a child under 18 years may stay longer if the Director of the Mental Hygiene Division of the Health Department approves.

(b) *"Marylands" Christchurch.*—Conducted by Brothers of St. John of God for training of feeble-minded (special class level) boys, this home received a capital subsidy and daily maintenance of 5s. per person. Roll 35.

(c) *Hohepa Home, Napier.*—Rudolf Steiner School. Roll 30. No subsidy.

(d) *Corstorphine, Dunedin.*—Planned as long stay home for subnormal women by the Presbyterian Church. A capital subsidy has been approved.

(e) *Our Lady's Homes of Compassion.*—On May 3, 1958, these homes were caring for: Idiots 3, Imbeciles 13, Feeble-minded 23. Total 39.

(f) *Senior Occupation Centres.*—These are to be conducted by I.H.C.P.A. for over-18-year-olds and they may obtain 50 per cent capital subsidy.

III. Shortcomings in the Existing Services

14. *Gross Inbalance Between Intramural and Extramural Provisions*

The position in this regard is severely out of step with what has already been achieved elsewhere (subsection 10) and with the contemporary view (subsection 5) of developments deemed desirable in future planning.

In Britain[54], "the majority of defectives who receive care under the present mental deficiency service receive it in the form of supervision from the local health authorities while living in the general community, without compulsory control". In New Zealand, the reverse is the case—Section II indicates that whereas over 3,200 are in institutions under the Mental Hygiene Division and Education Department, there are considerably less than half this number in attendance at special classes and other extramural centres.

Furthermore, it has been calculated[55] that if the proposals of the Royal Commission are put into effect in Britain, some 16,000 patients will be discharged from mental deficiency institutions, two thirds of these becoming wage earners living in hostels, leaving 9.7 mental deficiency beds per 10,000 of the population (in New Zealand the equivalent of 2,231 beds).

In Holland[56], where extramural services are advanced, there are only 4,000 defectives in institutions, although the population is over four times that of New Zealand. On the other hand, 25,000 receive special supervision in ordinary society—some twenty times the number in this country.

15. *Extramural Services Sparse and Uncoordinated*

Apart from occupation centres and special classes, these services are severely inadequate and lack co-ordination, there being no authority responsible for them. In the organised sense outlined in subsection 10, no extramural service can be said to exist, although there are some facilities. Child health clinics have insufficient staff to provide the continued support and advice to the family and the family doctor that is needed in these cases (subsection 10a).

The greatest gaps are the complete dearth of trained social workers to facilitate rehabilitation and supervise adjustment, and of any local residential accommodation (see below, subsection 21).

A leading educationist writes to us as follows: "Discovery, diagnostic, and advisory services are patchy and consequently, on a national basis, inadequate and of various standards. While one does not want uniformity, one does look for adequacy. My remarks here refer to both educational-psychological and medical-psychiatric services."

16. *Insufficient Educational and Training Facilities in the Community Setting*

From subsection 11, it emerges that with barely 1,200 places in special classes and occupational centres, only some 0.2 per cent of the school population are being catered for in this way. This is far less either than the 1 per cent specified in subsection 5a or the 1–2 per cent provided in several countries)[57].

Vocational training for dullards in adolescence and adulthood, such as it is, or is proposed (subsections 11a and 23), is on a most inadequate scale and the need for sheltered employment and workshops is almost untouched.

17. *Insufficient Educational and Training Facilities in Residential Institutions*

There is a very serious dearth of educational facilities in the Mental Hygiene Division's institutions. In all these, there is only one trained teacher in employment, despite the evidence below (in subsections 19 and 20) that many patients are of occupation centre and some are of special class levels, if not better.

So far as we know, no training school (subsection 5a) seems to be projected and no professional educationist is involved in the planning of any teaching programmes. In late 1956, a training programme was introduced at Levin Farm and carried out with the most praiseworthy enthusiasm by the Training Officer there, who, however, has no formal qualifications. Although there are no trained teachers, we saw children in the school room there functioning at least at special class level. One of these had been committed to the institution as an idiot at the age of 18 months.

18. *Lack of Rehabilitation Programme in Residential Institutions*

Although there is a large proportion of dullards (subsections 19 and 20) among defectives in institutions, the discharge rate is low and there are some patients in long term care who could probably be rehabilitated without difficulty[58].

Planning for discharge and placement appears to be quite scanty. It seems that discharge seldom occurs unless there is a refusal to certify on the part of the medical practitioners called in to do so on the patient's 21st birthday. We were told of patients who successfully survived this haphazard arrangement, which necessitates their immediate discharge, and who became working citizens through their own efforts subsequently.

The absence of social workers in the Mental Hygiene Division mental deficiency institutions confirms that there can be no rehabilitation programme in the proper sense (subsection 5 b c).

19. *Institutions Too Custodial for Dullards and Too Isolated*

In line with the serious inadequacy of educational and rehabilitation programmes, it is our view that the turnover rate of institutions is too low and their population (of dullards, at least) too high. (The latter point is elaborated in subsections 14, 20 and 26).

For 1953–1956, the yearly average of leavers was 158. The turnover per 100 beds is therefore about five per annum. This is much lower than the national average of nine in England and Wales for 1955, lower still than the better institutions there in that year, and the increasing turnover rate there now (subsection 14).

The work of the institutions is hardly integrated at all with medical and other services in the community at large; socially, they are far too isolated.

Over 39 per cent of patients under care are feeble-minded (subsection 12a) and this seems to us too high a proportion of dullards. Among a random sample of patients at Templeton Farm[4], 26 per cent had I.Q's over 65, 14 per cent had I.Q.'s over 75, and 7 per cent were of normal intelligence—and the methods of testing made no correction for decline of scores with age.

The educationist, whose letter we quoted in subsection 15, went on: "I am also concerned about the presence of high grade educable cases in these institutions along with merely trainable ones. I know that some have personality difficulties which suggest the need for institutionalisation. I know also that the presence of some high-grades is useful for the running of the institution. To what extent the latter is ethically justified, I am not sure. I do wonder whether all high grades who are in institutions really need to be there. I also wonder what efforts are made to get them into gainful occupations."

20. *Procedure for Admission to and Reassessment in Institutions Unsatisfactory*

No psychological assessment, of a standard acceptable to us, is obligatory before admission can be arranged to Mental Hygiene Division institutions. This contrasts with the rigorous psychological testing that routinely must precede admission to a special class in a day school.

In view of the dangers of too early institutionalisation (subsection 7), it is disquieting that 17 per cent of first admissions during 1953–1956 were under five, and that even of these only 19 per cent were in the severest category of idiot. Of the total first admissions of all ages between 1953–1956, 39 per cent were feeble-minded, presumably dullard.

In view of the uncertainties of prognosis (subsection 6), the lack of any psychological staff to ensure adequate assessment after admission adds to this disquiet. It renders regular assessment quite impossible subsequently.

Adequate diagnosis and assessment before admission are not ensured by present procedures, and proper and regular re-assessment afterwards are not feasible with existing arrangements. The figures published in the Mental Health Statistics indicate that higher grade patients are admitted too frequently and too young.

Also no person over 21 can be admitted to a mental deficiency bed. We have been told of cases where parents have felt themselves forced to appply for committal of an ament simply to avoid him being placed later on, after their death, with patients certified on account of acute mental illness.

21. *Residential Amenities Geographically Inconvenient*

Some 1,990 of the 3,081 patients under care for mental deficiency by the Mental Hygiene Division are not in special institutions for the purpose. Instead they reside in the other mental hospitals with the consequence that a number of children are to be found sharing wards with mentally disturbed adults. In part, this is due, as the Director informed us, to the wish of parents to have their children in whatever institution is nearby so as to enable visiting. Nevertheless, it is a highly unsatisfactory arrangement not only for backward children but for adult dullards and aments whose special needs cannot be met if they are scattered about wards for other mental diseases.

The fact is that despite the relatively high number of beds for mental deficiency (subsection 14) the agglomeration of special beds in three centres means that most parts of the country have no suitable local provision whatsoever for residential accommodation. The functions which the modern institution must serve (subsection 9) cannot be met.

The need for local provision is brought out by the expert committee of W.H.O.[40]—"hospitals should be within easy travelling distance of the community whose needs they serve. Every effort should be made to provide transport which will enable parents to visit their children. Institutions in remote parts of the country have difficulties in maintaining contacts with home and with welfare agencies".

22. *Dearth of Professional Personnel*

Apart from the severe lack of psychiatric social workers already emphasised, there is in New Zealand very little professional specialisation on the educational side of mental deficiency and even less on the medical side. Levin and Templeton Farms each have no more than one doctor: neither has trained teachers, clinical psychologists, physiotherapists, speech therapists.

Among the most urgent needs is trained workers in this field and we consider that expenditure on this rather than on enlarging the Mental Hygiene Division's institutions should receive first priority.

One physician wrote to us, concerning Levin Farm: "One doctor to 500 mentally sick children is not only inadequate, it is pathetic. As a result it is inevitable that physical illness in these children receives sub-standard treatment . . . and public indignation could be easily aroused. However, even worse than this is the further consequence that a child might well be admitted . . . whose brain is potentially normal . . . what possibility would there be of the mistake being detected?"

IV. Appraisal of Official Policy

23. *The Aitken Report*[1]

The Return in which the Minister of Health reported to Parliament in October 1957 makes it clear that the Aitken Report is the basis of official policy and much public expenditure. "With the proposed legislation at present before the House, all the recommendations of the Consultative Committee are being implemented . . . apart from this need for further (residential) accommodation, which is being met as quickly as possible, it appears that the demands have been met".

We have a number of criticisms of this document:

(a) *Out of Touch With Contemporary Ideas.*—There is no hint in the report of the stream of new ideas, inquiries, publications, and programmes in this field overseas. Indeed the only reference to any community studies elsewhere is a single item from a British Committee in 1929[59], while throughout its 43 pages, the word "rehabilitation" is not mentioned once—a remarkable omission.

(b) *Mistaken Over-emphasis on Institutional Care.*—This emerges in the Committee's findings, such as paragraph 51: "We conclude that the only satisfactory policy is the provision of good residential institutions, well equipped and well staffed, for the greater majority of imbecile children, and the encouragement of parents to place their children therein at the age of about five" (this latter recommendation has been rejected by us in subsections 6 and 7), and paragraph 58, "once the institution has accepted responsibility for an imbecile child, it should be prepared to look after him for the rest of his life".

All this appears to be based on a conclusion stated in paragraph 49: "Nearly all imbecile children who survive into adult life will eventually have to be cared for in institutions when their parents are no longer able to look after them." Apart from the independability of prognosis already mentioned here (subsection 6) this statement is quite erroneous. In modern communities one half to three-quarters of the ament population survive without institutional care at any time[11, 15, 60].

(c) *Main Recommendations Impracticable.*—These recommendations are not only out of harmony with modern knowledge (subsection 8), but as quoted above are impracticable. In subsection 3, we point out that the Aitken Report greatly under-estimates the likely incidence of aments in New Zealand. Even if the present 3,000-odd beds were to be cleared of their 37 per cent dullards (subsection 19) and used exclusively for aments, another 3,000 beds in addition would still scarcely meet all the 6,800 that we calculate to be living throughout New Zealand.

Moreover, in paragraph 57 of their Report, it emerges that the Aitken Committee did not even envisage that the institutional accommodation it proposed should be exclusively used in this way for aments—they advise that no less than 25 per cent of the beds be for feeble-minded.

At only £1,500 per bed (now a gross underestimate) the capital cost of 3,000 would be £4.5 million, and their annual maintenance some £1.7 million per annum (i.e., at the present annual cost per bed in Levin Farm of £475 plus interest on capital outlay per bed at 5 per cent, £75).

Even if the country could afford such an enterprise we strongly believe that it would be well advised not to do so.

(d) *Type of Institutional Care Recommended is Antiquated.*—The Committee in paragraph 53 of its Report specifically rejected smaller groupings or homes, and in paragraph 57, advised residential units of 30 in large institutions of 400 to 600. This is out of date, and psychiatric knowledge today emphasises (subsections 9, 25, 26) small units singly as hostels or set in small institutions. Furthermore, this advice of the Committee for the agglomeration of beds in few large institutions ignores the geographical needs of the population for conveniently local accommodation (subsection 21) and would heighten the prevailing social isolation and custodial nature of the residential institutions.

(e) *Failure to Appreciate Remedial Possibilities.*—As already remarked above the Committee makes no mention of rehabilitation and appears to have

accepted profoundly pessimistic ideas, taking no account of therapeutic advances elsewhere.

Thus the need for day Occupation Centres, run by the Education Department, was only adopted reluctantly in paragraph 61 "because some parents will prefer to keep their children at home" and "because good institutional provision is likely to lag behind the demand for it". However, the necessity for any special course of training for the staff of occupation centres, which was suggested to the Committee, was rejected in paragraph 61b). Speech therapy, they declared, "had little or nothing to contribute to the development of speech in lower grade mental defectives" (paragraph 70), while in one blanket pronouncement (paragraph 71), occupational therapists, handicraft teachers, physical educationists were all found to have only a limited contribution. Their employment at Occupation Centres or residential institutions is declared to be unnecessary, though somewhat grudgingly, the Committee agreed they might visit occasionally and that a large institution might "possibly" have a place for an occupational therapist.

24. *Outline of the Building Programme of the Mental Hygiene Division*

The Minister of Health's Return to Parliament in October, 1957 (quoted above in Section II) describes the projected capital expenditure from 1957 to 1960 of £1,113,780 on buildings at Levin Farm and Templeton. Already 200 new beds at Levin had recently been completed and 200 more were now to be started, with 150 new beds and an admission block (presumably containing more beds) for Templeton in 1959. Not included in this expenditure is a new institution (probably with 750 beds) in Auckland, for which 126 acres at Mangere had recently been purchased for £40,000. We estimate that capital outlay in the region of £3,000,000 will be required for this institution, a vast expenditure which we firmly regard as unjustifiable (subsections 25, 26). Moreover, we feel that the needs of more persons could be met by the modern approach (Section V), and that any money to be spent should provide for trained personnel rather than more buildings. For Auckland a pilot scheme (see below Section VI f) along modern lines would be far more worthwhile at this time.

By contrast with this very heavy expenditure on intramural accommodation in the Mental Hygiene Division's institutions, capital subsidies to Short Stay Homes (see above subsection 13a), and capital expenditure by the Education Department on Occupation Centres (see above subsection 11c) over the previous seven years was only £50,000. Also in 1957–58, the annual expenditure (excluding the cost of these buildings) by the Education Department on intellectually handicapped children was a mere £36,000, admittedly a 400 per cent increase on 1949, but still no more than, at 1957 prices, would just maintain 75 residents at Levin—a trifle compared to the number of aments (let alone dullards) in need of facilities in the outside community.

25. *Criticism of the Programme 1.—Its Misguided Emphasis on Beds*

We have already made it clear that there is a gross deficiency in the extramural services in this country and implied that there is an outstanding need for these to be developed rather than for mental institutions to be immediately enlarged by several hundred beds (subsections 6, 7, 8, 10, 23b).

Our elementary computations suggest (subsections 3 and 23c) that even two or three thousand more beds would not really cater for the aments in the population (let alone dullards) and the several hundreds planned are scarcely likely to do so at all.

If it be argued that there is an urgent waiting list of the severest, lowest grade, and most helpless aments, it remains a fact, as we have indicated in subsections 19 and 20, that dullards form 37 per cent of defectives in institutions and 39 per cent of those being admitted. Even among under 10's, the admissions for 1953–1956 included only 19.7 per cent of idiots (52 out of 264), the rest being of a higher grade.

Although the Deputy Director of the Mental Hygiene Division[61] has stated that "institutions are overcrowded and waiting lists are long and waiting times are over three years", his conclusion that "there is an immediate need for another mental deficiency colony" does not necessarily follow. A rehabilitation programme, as we have indicated, will liberate beds, and an extramural service with revision of the admission policy (subsections 5, 6, 14, and 20) will reduce the waiting list.

In fact, there is no information, aside from admissions (subsection 20), as to what the composition of the waiting list may be. Nor is there any information of any detailed and scientific kind as to the pathology and psychological make-up of the institutional population of mental defectives in New Zealand (what little there is has been quoted before[4,58,62]). Learning from a visit by some of us there that certain cases at Levin Farm had recently undergone testing by a psychologist visiting from the Education Department, we approached the appropriate Departmental officer for his findings. The letter in reply states[63]: "For a number of reasons, it is inappropriate for us to obtain the figures you have inquired about even for our own use, in the meantime . . . " and we were advised to inquire of the Director of the Mental Hygiene Division. This we did in a letter of October 13, but have received no reply. We are unable to see any justification for technical information of this simple kind either being withheld from this B.M.A. Subcommittee or being "inappropriate" for the Education Department to use.

In view of the lack of any satisfactory data both as to the category of cases at present in institutions and the composition of their waiting list, it appears reasonable to advise that a survey by an independent, scientific team (sponsored by the Medical Research Council or the Otago Medical School) be made to discover the facts first before embarking on any great expenditure on more beds in large institutions.

This appears particularly prudent when such a plan goes in the reverse direction to modern developments and policies overseas (subsections 8, 9, 10).

26. *Criticism of the Programme 2.—Mistaken Preference for Large Institutions*

The insistent favour for large institutions has already been touched upon (subsection 23d) but requires some closer criticism. This aspect of the Aitken Report as the inspiration of official policy is underscored by the Director of the Mental Hygiene Division in his Annual Report, 1956: "By and large, it can be said that the intellectually handicapped are happier amongst their own. They enjoy a community life in which the competition and the striving is not too great for their intellectual capacity. This can be achieved by residence in colonies much larger in size than is often contended. After years of experience, this Division still holds the view that the colony of 750 gives a much wider scope for these "children" and a much happier environment than the restrictions imposed by a smaller one."

The structure and staffing of existing institutions (subsections 19 and 22) do not permit the experience on which modern developments are based. We have indicated before, in subsection 9, that to come up to standard, a residential institution must not be too large and that it must be integrated with the community and have its extramural services. Also, we have pointed out in subsections 17 to 21 that the existing institutions are not properly

integrated in this way, being too socially isolated. As any special residential accommodation is concentrated in two centres, the outcome is that neighbourhoods distant from these have almost no provision at all for local needs, and many patients are quite unsuitably placed in mental hospitals in order not to make visits by their relatives impossible.

The superiority of the neighbourhood hostels and other small units is not only "often contended", as the above quotation suggests, but is the considered opinion of world wide authority. The necessity and practicality of small units and cottage type care comes from the established experience of internationally famous institutions such as the Vineland Training School and Letchworth Village, founded respectively in 1888 and 1908.

The W.H.O. Expert Subcommittee[40] advises, "Hospitals should be divided into small units . . . located in or close to urban areas . . . within easy travelling distance of the community whose needs they serve . . . Institutions in remote parts of the country have difficulties in maintaining contacts with home and with welfare agencies".

The British Medical Research Council workers[64] studying methods for rehabilitating mental defectives flatly state, "In our view, large institutions are unsatisfactory places for training."

The British Royal Commission[65] is equally emphatic: "Many persons now classified as imbeciles and the majority of those now classified as feeble-minded are able to live in the general community with relatives or friends and are accustomed to mix and work with other people; if their relatives or friends die, or become unable to give them a home any longer, they need to be provided with a home . . . if otherwise suitable to live in a local authority's welfare home, they should be accepted there and not sent to a mental deficiency hospital where they will be largely cut off." Again, the Commission states: "for those who cannot live with their own relatives, it is considered more appropriate to provide residential homes in towns and villages, with as many as possible of the residents working in normal employment, and the others having suitable occupation either in the homes or hostels themselves or in some form of sheltered employment or occupation centre."

And to this the Report adds: "Residential homes provided by the local authorities should not be large institutions. Twenty to thirty residents might be a normal size . . . they should not be in isolated places, but in or near enough to towns or villages for the residents to participate in the life of the general community as far as they are able."

As for the view quoted that mental defectives are "happier among their own", which also figures in paragraph 49 of the Aitken Report, we know of no scientific evidence for it. As the Royal Commission states, and as we indicate in subsection 23b, most aments, so far as is known, never enter institutions. It has never been demonstrated that they are or would be better adjusted in institutions, and there are, in fact, studies to the contrary showing that they tend to be quite happy outside (in addition to the prognostic studies referred to in subsection 6). A Commission of the Massachusetts Legislature[66], for example, found that severely retarded children who are kept in the community are trained to carry out simple tasks, to work in a group, and to develop a modicum of socially acceptable behaviour.

The finding that aments do well in their own homes is brought out in an extensive and very important investigation[60] into the adjustment of severely retarded adults in the community. This work was conducted by a university team including trained social workers on behalf of the New York State health authorities and confined itself to persons of I.Q. below 55, Data for 2,640 individuals, first observed in childhood, and now aged 17 to 40, were obtained. Of these only 26 per cent had been institutionalised and a significant discovery

was that where families were tense and in emotional conflict, the defective child was thrice as likely to be placed in an institution as in warm, closely knit families. Most patients were considered to have made good adjustments in their home environment; 75 per cent of the parents felt that they were easy to get on with, created no major difficulties, and could safely be left alone; and 27 per cent worked for some payment. The majority of parents had given thought to the future and 80 per cent hoped or planned for the patient to remain in the community.

In this country, most aments reside outside institutions and do not receive any special facilities for their care. We recommend that an investigation similar to this one in New York, be undertaken here into the condition of aments in the general community.

V. Outline of a Community Service for Mental Deficiency

For the needs of this country, the planning of a mental deficiency service has to take special account of there being a very small population with many towns that are widely scattered geographically. This does not allow of duplication of facilities and in any neighbourhood, they should be shared by and equally accessible to patients either under residential care or living in the outside community. Local administration of intramural and extramural services would be necessary for this as well as more efficient in other ways.

The diagram illustrates that the patient, who may be in one of three locations (at home, in outside placement, or in an institution), must have access to three kinds of provision. These services are indicated on the diagram as "clinical", "training", and "vocational", and they include certain facilities listed there in each group.

In the main we envisage that these three categories of services would be predominantly extramural in setting (i.e., that patients in institutions or otherwise under care away from home, would go "out" to them daily). In some cases, institutions would contain these facilities within their precincts and then patients resident in the locality would come "in" to them daily.

The most significant novelty in the service proposed would be the growth of a number of modest country-house type[67] institutions to cater for patients needing residential care. These would be dispersed throughout the country to meet local needs, to avoid separation from the family, and to permit both continued participation in community life and gradual rehabilitation of many cases to independence in it. Such institutions would comply with the modern developments in mental deficiency practice specified in this report and with the recommendations of the British Royal Commisssion (in particular, see subsection 26).

Crawford, who speaks with experience of them says[67] that "by the placement in strategic areas of country house establishments, minimally staffed and equipped . . . (patients) whose home care had deteriorated or ceased could be cared for. With only slight support and supervision they can minister to their own daily wants and possibly staff a sheltered workshop".

In our view, for New Zealand, small residential centres of this kind are much more appropriate than large institutions. They would be readily available through the purchase and conversion of older properties and they would serve as a point of intersection for the various medical, educational, and remedial services, as a base for social workers, and as a focus for the surrounding community, its voluntary bodies, and parents' organisations. Medical care could come from general physicians and nursing could be organised by a general trained resident matron, utilising local unskilled and patient labour, and part-time assistance from relatives and other

interested persons. Staffing of this kind is a realistic possibility and makes no demand for the very specialised experts necessary for the large institution.

For the clinical services listed in the diagram we would envisage pædiatric or psychiatric clinics in general hospitals with some diagnostic beds, and the personnel listed under "organisation".

In the administration of the service there should be considerable local autonomy, with perhaps joint sub-committees of hospital and education boards, stiffened with parents, voluntary bodies, medical and other professional workers, and possessing statutory powers. Any central co-ordination would be in the hands of the Education Department. Two considerations in particular have led to this view. One is that the medico-pathological aspect of mental deficiency is relatively confined and that in its management education and rehabilitation loom large; the other is the fact that the Education Department already supplies some extramural facilities in its occupation centres, special classes, and psychological service, and its activities are traditionally rooted in the ordinary life of the community.

VI. Summary and Recommendations

Here we list our findings and the recommendations we have made so far, together with a few others in addition. These are not given in any order of importance.

(a) *Recommended Nomenclature*

The terms "mental deficiency" and "congenital mental deficiency" ("C.M.D.") are not medical diagnoses in the proper sense. They should no longer be used as such, unless further qualified. The terms "ament" and "dullard" should come into general use and the terms "idiot", "imbecile", and "feeble-minded" should be discarded (subsections 1, 2).

(b) *Modern Practice in Mental Deficiency*

Plans and policies for the mental deficiency services must take account of the following:

(1) The capacities of dullards and aments are greater than has traditionally been supposed. This refers both to their potential for useful employment and for social adjustment (subsections 4, 5, 6, 26).

(2) Full training and rehabilitation of dullards and some aments, and useful training of most aments can now be based on established principles and experience. These include educational programmes from early childhood, and vocational training in adolescence and adulthood, which require special schooling facilities, sheltered workshops and employment, and supervising social workers for cases in the ordinary community and in residential institutions (subsections 4a, 5, 9, 10a,b,c).

(3) The prognosis of mental defect is uncertain and unreliable, especially in children, and even more so in young children. Institutional admission may be dangerous if it is too early and we regret the general recommendation in the Aitken Report that children be admitted as a rule at the age of five to this country's institutions (subsections 6, 7).

(4) Skilled and elaborate pædiatric and psychological investigation, before admission, with repeated reassessment afterwards, should be mandatory. Isolated intelligence tests by untrained testers (whether medical or other personnel) do not meet these requirements (subsections 6, 15, 20). The

existing procedures for admission and subsequent assessment are, by these standards, highly unsatisfactory.

(5) There is a worldwide shift of favour away from institutional care for the mentally ill and mentally defective and towards extramural services maintaining the patient in the ordinary community (subsections 8, 10, 14, 26).

(6) Extramural community services should include clinics (for detection and assessment of cases, supplying remedial treatments, and counselling of parents), guidance and supervision by psychiatric social workers, special educational and vocational training programmes, economic aid to families, foster home care in selected instances, and should encourage voluntary organisations of parents (subsections 8, 10).

(7) Residential institutions should serve three functions—short term care with rehabilitation; brief and promptly available care in the event of illness, domestic crisis, and family holidays; long term care and training for a proportion of aments, who nevertheless should remain easily accessible to their families to whom they belong (subsection 9).

Residential institutions should not be large and they should supply a hostel atmosphere for adults, and a small group or cottage setting for children (subsections 9, 26).

Residential institutions should either supply special education, remedial specialists, vocational training, sheltered workshops, or have access to them in the extramural services in the neighbourhood. Their functioning should be well integrated with the latter, especially through the agency of psychiatric social workers (subsections 5, 9, 21, 26).

(c) *The Existing Services*

In New Zealand, there are probably about 6,800 aments and 50,000 dullards. The estimates in the Aitken Report on which Government policy has been based are much too low (subsections 3, 23c).

The existing mental deficiency services supplied by the Education Department, Health Department, and voluntary bodies are listed. These include over 3,000 beds for mentally defective patients in Mental Hygiene Division Institutions, 122 places in residential schools, and about 200 residential places, short and long stay, maintained by voluntary organisations. Some clinical services are rendered at Child Health Clinics and a few psychiatric outpatient departments. There are about 1,200 children receiving education in special classes, occupation centres and occupation groups and some adults attending senior occupation centres and occupation groups (subsections 11, 12, 13).

(d) *Their Shortcomings*

(1) *The Extramural Services.*—There is a gross imbalance between the intramural and extramural provisions and in this respect New Zealand is already lagging far behind some other countries. The ratio between the two here is the very reverse, in fact, of what would be desirable in the future (subsection 14).

The extramural services are sparse and unco-ordinated, clinical facilities being insufficient to supply the continued support and advice needed by patients and their family doctors (subsection 15). We would suggest here that there is much to be said for making amentia a notifiable condition.

In the community setting, special education facilities are insufficient and vocational training and sheltered employment are entirely inadequate (subsection 16). They might be promoted by the establishment of a disabled

persons register and an obligation on employers to take a proportion of handicapped persons.

(2) *Institutions.*—In the institutional setting, educational and training facilities are all more severely inadequate still and there is no proper rehabilitation programme (subsections 17, 18 19).

Institutions are too isolated socially and scarcely integrated with medical and other social services in the community (subsections 19, 21).

Too high a proportion (37 per cent) of patients in residential care are dullards and their treatment in the absence of a rehabilitation programme, is too custodial (subsection 19).

While the number of institutional places may be sufficient, or even perhaps more than sufficient, the agglomeration of special facilities in two or three centres means that most parts of the country have no suitable local provision for residential accommodation. One consequence is that most persons in residential care on account of defective intelligence are scattered in hospitals for the mentally ill. Neither for backward children nor adults is this acceptable as satisfactory (subsection 21).

The procedure for admission to institutions, as already noted, is unsatisfactory and such arrangements as there may be for subsequent re-assessment are entirely inadequate. At present, too high a proportion of admissions are dullards; probably too high a proportion are admitted early as young children; and we note that even for under fives admitted for the first time between 1953 and 1956 inclusive, only 19 per cent were of the severest category (viz., "idiot"). The bar to first admission for mental deficiency after the age of 21 is an anomaly and occasionally precipitates admission before it is really required (subsection 20).

The present procedure for institutional admission by medical certification and judicial committal is unsuitable for the requirements already specified above, hazardous for the patient, not protective of his interests, and offensive to relatives. It should be discarded and the actual process of admission should be informal. Any necessary reform of the law to bring this about should be pursued (subsections 6, 9, 20).

(3) *Professional Staff.*—There is a dearth of appropriately trained personnel, and especially of social workers. Also institutions lack trained teachers, clinical psychologists, remedial therapists. Their medical staffing is absolutely inadequate (subsection 22).

(e) *Official Policies and Plans*

The basis of official policy is the Aitken Report of 1953. This document is out of touch with contemporary ideas, and contains an erroneous and extreme over-emphasis on institutional care its recommendations for which, in face of the size of the problem, are impracticable. The type of institutional arrangements it advises is antiquated and it appraises remedial methods too pessimistically (subsection 23).

The building programme (over £1 million) of the Mental Hygiene Division, at present in hand, is outlined. By contrast, the Government's expenditure on extramural education and training facilities is low and in extreme disproportion. The new institution proposed in Auckland would, we estimate, cost some £3 million in capital outlay alone—an expenditure we find unjustifiable, if not pointless in the light of present knowledge (subsection 24).

Official policy has a misguided emphasis on extending residential accommodation and a mistaken preference for large institutions. Both are opposite in direction to modern opinion and to trends elsewhere (subsections 25, 26).

(f) *Recommendations*

It is our view that the nation's plans and expenditure in this field be revised so as to conform with the modern developments to which we have drawn attention in this Report. Certain of our recommendations, such as that amentia be made a notifiable disease, that the procedure for admission to institutions and subsequent reassessments be drastically revised and that a Disabled Persons Register be established have already been stated above, and others now follow.

There are no scientific data as to the pathological and psychological make-up of mentally deficient persons in residential care and on the waiting list of institutions. A little information appears to have been gained lately but it was not made available to us.

Before there be any further great expenditure on residential buildings, such data should be obtained by an independent scientific team (subsection 25). An investigation is also recommended into the situation of aments in the outside community, where most of them reside (subsection 26).

There is a need for medical instruction in mental deficiency. In undergraduate teaching, more attention should be paid to mental deficiency. A postgraduate course in the subject should be planned and, in the meantime, training overseas should be made available. A training programme should also be initiated to provide other professional personnel in the field, viz., psychiatric social workers, clinical psychologists, teachers, speech and occupational therapists.

We recommend a community service along lines described in Section V. There would be an expansion of extramural services with the aim of rehabilitating dullards and supporting aments in ordinary society; cases requiring residential care would receive it in neighbourhood hostels or large houses converted for the purpose; there would be an emphasis in expenditure on trained personnel rather than on erecting institution buildings; and there would be greatly expanded participation by general practitioners and the educational profession.

The need for residential accommodation in this country should be met by small neighbourhood hostels and not by enlarging the already too large institutions. Such hostels would cater for adults who could work locally for a wage as well as for children. Thus the cost to the community of residential care would be reduced (subsection 26, and Section V).

To encourage and facilitate extramural care in the interests of the patient, and to discourage too early admission to institutions we advise:

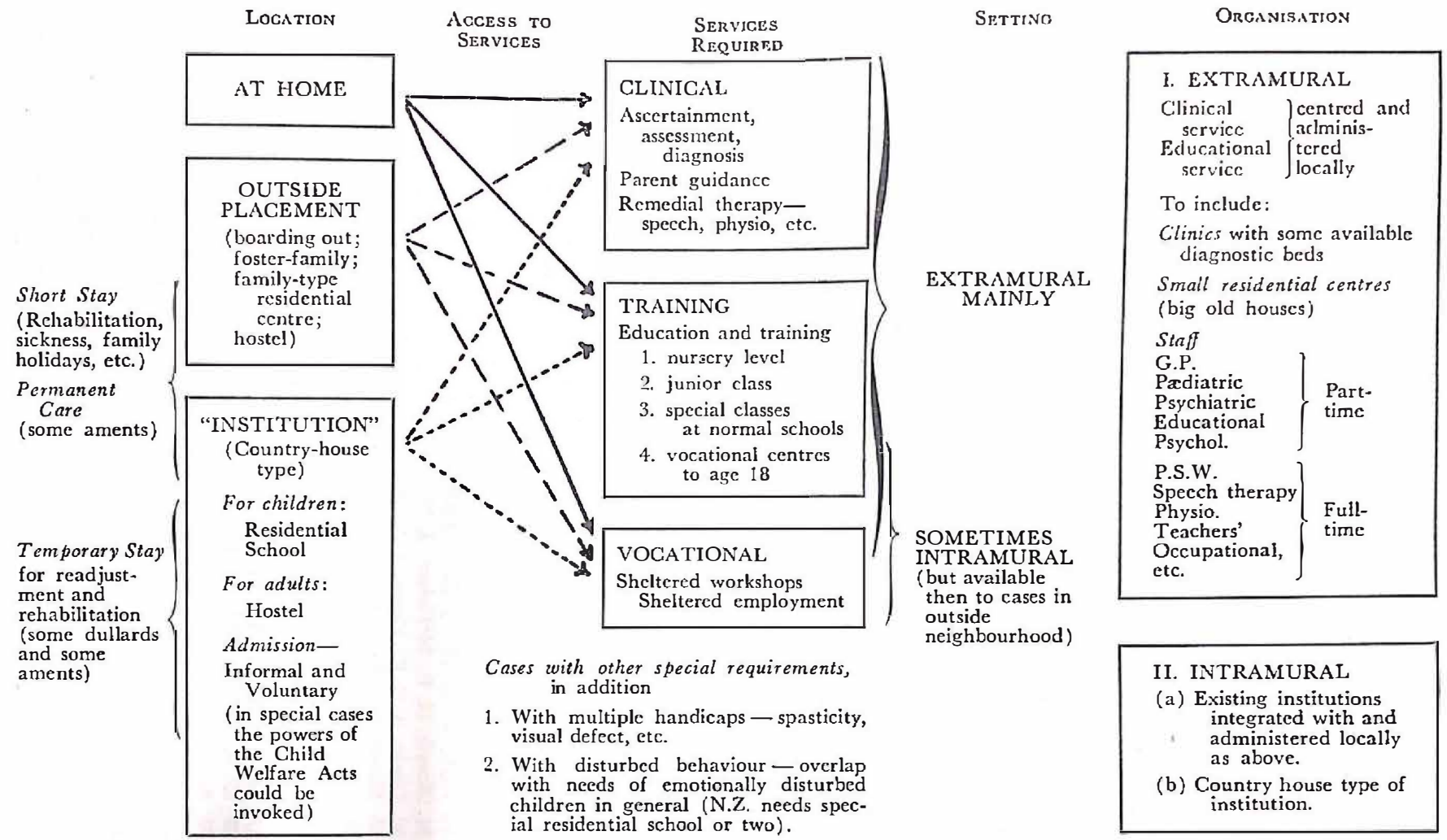
(a) The payment of extra child allowances to mothers of aments—a measure that is, incidentally cheaper than maintenance in a hospital.

(b) Realistic levels of payment for foster mothers.

(c) A register of suitable foster homes (subsections 7, 8, 10).

Throughout this report we quote opinions of accepted authorities in this field in support of this approach and remarking on its economy in comparison to institutional treatment. Instead of the large institution proposed at Mangere, Auckland, costing some millions of pounds, we suggest a pilot scheme there based on the above principles with a hostel, sheltered workshop, training and education centre, serving the general community.

The community service, as envisaged in Section V would be administered with considerable local autonomy and with the participation of voluntary bodies, parents, medical and other professional workers, as well as representatives of hospital and education boards. Any central co-ordination would be through the Education Department while special facilities in any locality would be equally accessible to patients in residential care and living in the outside world. Predominantly, the services would be extramural.



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