A flexible system of care for the mentally handicapped, based on the community to which they belong, is an essential step towards their true integration into the mainstream of life. A scheme, devised on this principle, is in the early stages of implementation in Sheffield.

Over the past few years, the existing patterns of care for the mentally handicapped have been subjected to a great deal of criticism. The accommodation provided has come under close scrutiny and arguments about demand and resources are open-ended. The approach for the Sheffield Feasibility Study was to fully assess the problem, starting from first principles.

In 1969 a multi-disciplinary team of administrators, doctors (psychiatrist and paediatrician), nurses, social workers and architects from the Department undertook an analysis of the problems of early identification, comprehensive assessment and re-assessment, the provision of training, medical and social services, and accommodation.

It was agreed that the team should consider simultaneous co-ordinated and comprehensive planning in both the hospital and community sectors of services and explore the problems of introducing a pattern of service based on district general hospitals instead of specialist hospitals for the mentally handicapped. The object would be to design a service incorporating up to date ideas which could be evaluated in practice, rather than to design a model service to be copied generally.

The implications of these findings were studied in relation to a specific urban area – the County Borough of Sheffield, where the existing services were evaluated in detail – to determine whether a new pattern of care was feasible.1

The team’s report recommended a dispersed pattern of service and smaller units of accommodation to preserve personal contact using appropriate local services where possible.

The dispersal pattern acknowledges that mental handicap is a social/educational as well as a medical/nursing problem and that mentally handicapped
people could benefit if they lived in smaller groups in a stable domestic setting integrated with the community.

Dispersal has been organised by defining the component parts of the new service and the interaction between them. In short, this led the team to the conclusion that early identification, assessment and re-assessment should be considered as the nucleus of the service and the centre, from which referral would be made to other component parts - to be provided by the Regional Hospital Board, the teaching hospital and the local authority.

The hospital and local authority services will therefore provide a hierarchy of accommodation which should ensure progression from one type of accommodation to another by the mentally handicapped if and when appropriate and as recommended by the assessment service.

The assessment service should allow for multi-disciplinary assessment of each handicapped person. Re-assessment should consider growth, development and the effect of treatment, training, education and environment. Specialists from both the hospital and local authority services concerned with medical, social and educational assessment are expected to participate in order to provide an integrated service for all age groups with any handicap.

The hierarchy of accommodation proposed for the northern half of Sheffield for a population of (say) 250,000 can be summarised as follows:
In considering the design of residential accommodation it was recognized that the degree of medical and nursing dependency of those who would use the accommodation would be a very important factor. Designs were therefore based on three broad classifications, as follows:

GROUP A: For those requiring substantial medical and nursing care.

GROUP B: For those requiring some continuing medical and nursing care.

GROUP C: For those requiring no continuing medical and nursing care.

The provision proposed for the local authority follows the principles and patterns which have been established since 1957, with the important difference that the study emphasises the social and educational needs of pre-school age children living either with parents or in a substitute home.

Accommodation provided by hospital services prior to the study had to be reviewed and it seemed appropriate that the team, formed to consider a new pattern of service, should also consider the kind of buildings required.

The team's investigations defined room activities, sizes and relationships, relative to agreed group sizes and care procedures for hospital accommodation based on a dispersal pattern. It was envisaged that the work undertaken and the documentation compiled could form the basis for further work to produce detailed designs, costs, etc. for buildings to be erected as part of the Sheffield Development Project.

The assessment centre, serving the whole Sheffield County Borough catchment area, was considered as an extension to an existing centre for the assessment of handicapped children. A schedule of areas was arrived at to ease the work that would be carried out by the assessment team to be made up of:

1) Medical and para-medical staff (paediatrician, psychiatrist, physio-, speech and occupational therapists and other specialists as required).
2) Local authority specialist and supporting services staff (doctor, educational psychologist, teacher, social worker and health visitor).
3) Case register data collection staff.
4) Administration and clerical support.

Six other hospital building types were considered. Although a dispersal programme of the scale envisaged for Sheffield implies a major transfer of care from hospital to community services (working, ideally, to support and advise families wishing to care for their own relatives), established populations of the existing specialist hospitals were also to be planned for as well as the relatively small number of children and adults who, for a variety of reasons, need some form of hospital day or residential care. In this context, hospital provision refers to:

a) accommodation on the fringe of a district hospital site, where the building should, if possible, be domestic in scale and should relate to (and be visually integrated with) near-by housing rather than the hospital departments, and
b) accommodation located elsewhere in the community, away from the hospital complex in established residential areas.
Group A residential accommodation for children is to cater for those who (because of additional heavy handicaps or severe behaviour problems) require the support of a full hospital service fairly close at hand. Each functional unit of 24 places should provide for three ‘family’ groups of 8 children, each group clearly identifiable as occupying a separate home, although some common services and spaces will be shared by the whole unit.

A proportion of the first admissions to this type of care will be drawn from an existing specialist hospital for the mentally handicapped and a few will have lived at home where they may have attended a special care unit run by the local authority.

Each group or ‘family’ will cater for boys and girls of varying ages and handicaps, and it was agreed that two single rooms, one double room and one four-bedded room should be provided with provision for conversion if necessary to cater for the changing needs of older children who may benefit from greater privacy. Activities within each ‘home’ are essentially small family group activities, providing a stable domestic situation. It is hoped that some of the children will transfer to Group B accommodation. Some, however, on becoming adult, will move to Group A residential accommodation for adults.

A day care unit for 25 children will be associated with a 24 bed Group A children’s residential unit. The function of the day care unit will be to provide the children from the residential unit (and, in one or two cases children living at home) with a structured day, with therapy, training, play and education in its widest sense, and a complete change of environment.4

The day care unit will also provide recreational facilities during evenings, holidays and weekends for all the children, including some who live with their parents. The unit will have child care staff and local education authority teaching staff in addition to nursing staff drawn from the associated residential unit. Speech and physiotherapists from the assessment service will be available to advise and work with unit staff for specific activities.

It was agreed that a large social space will be required as the whole group of 25 children will need to meet together at times. During a typical day the children and staff will feed into and move through this social space into adjacent areas which should clearly relate to it.

4. A special care unit, having a similar function to the day care unit, is provided by the local authority in Sheffield for severely handicapped children cared for at home.
A possible breakdown of the total group of 25 children during a typical day when large group social activities are not taking place could be:

- 6 children in the ‘locomotion’ (physiotherapy) area, for any one session, with 2 members of staff excluding the physiotherapist who may not be in attendance continually.
- 6 children in the adventure area – again 2 staff should be available to be on hand during adventure play, constructional play and possibly sand and water play.
- 6 children in teaching room 1 with 2 members of staff.
- 2 children in teaching rooms 2 & 3 each with 1 member of staff.

The remaining three children could be in the large social space, the therapy room, the kitchen or the bathroom/wc areas for habit training, or even off-site shopping or visiting.

This grouping arrangement will be flexible depending on each child’s individual requirements but these grouping sizes should be taken as the maximum for small group activities.

Group A residential accommodation for adults is to cater for those requiring full medical and nursing facilities. Four 24 bed functional units are to be located on a district general hospital site, allowing each unit to be visually identifiable as an autonomous group.

It is envisaged that, within a 24 bed unit, the sexes will be mixed for most activities, although opinion varies about separation of bed areas. The agreed design solution provides that each unit has living, dining and sleeping areas to accommodate two groups of 12 and varying sizes of bedroom, thus allowing for local decision on the mixing of sexes within this smaller group. The units need to provide a domestic environment with adequate space and facilities for all activities associated with ‘home’.

A day care unit for 115 will be associated with the four 24 bed Group A residential units for adults. The function of the day care unit will be similar to that of the unit for children, but it will also provide sufficient
day care facilities for some heavily handicapped adults living at home to spend at least part of the day in a different care situation.

It was agreed that two teaching and training activity areas, each containing several spaces of different sizes and each incorporating two bathrooms and toilets for self-care training, should be provided. These teaching areas will each serve two 24 bed residential units and a number of adults living at home.

Suggested maximum groupings were:

- 'Locomotion' (physiotherapy) – 6 adults & 2 staff.
- Adventure – 10 adults & 2 staff.
- Teaching rooms 1 – 12 adults & 2 staff in each of two rooms.
- Teachings rooms 2 – 8 adults & 1 or 2 staff in each of two rooms.
- Teaching rooms 3 – 8 adults & 1 or 2 staff in each of two rooms.
- Teaching rooms 4 – 8 adults & 2 staff in each of two rooms.

This would leave 4 staff to look after 27 adults likely to be in other parts of the building—and it was agreed that a free area 'social space' should be incorporated in the central area to cater for this group.

A large social area will be required as the whole group of 115 adults will need to meet together at times. The space to be allocated for the free area (social space for 27 adults) 'locomotion' and adventure should be utilised for this purpose.

Group B residential accommodation for children is to cater for those who need limited medical and nursing supervision but can generally attend local authority special schools. As with Group A residen-
tial units for children, a functional unit of 24 should provide 3 autonomous ‘family’ groups of eight.

Medical attention will be given by a visiting paediatrician or local GP in the hostel. They will use local recreational facilities, shops and other community facilities.

Each ‘family’ group will contain boys and girls of varying ages and handicaps. The housemothers for each group will be two single people who will provide stable and consistent relationships for the children. It is not considered essential that the housemothers should be nurses, but they must have training or experience in child care. Housemothers will identify with smaller groups of children and have bed/study space with their ‘family’.

Some of the children will transfer to Group C accommodation or return to their parents, whilst others, when adults, will move to Group B residential accommodation for adults. Group B residential accommodation for adults will be similar in concept to the Group B residential units for children. However, the adults will be cared for by non-resident hospital staff and will have staff on duty at night, and ground floor bedrooms for the physically handicapped will be provided. The adults will attend local authority adult training centres.

Apart from the new facilities proposed the team made a number of recommendations about the running of the service. Amongst these were:

(i) the existing services provided by family doctors, health visitors and social workers should continue but with the social work service reorganised so as to provide an expanded joint hospital and local authority service, giving substantial support to the mentally handicapped and their families;

(ii) important recommendations about the training of staff for the new service. Amongst the proposals were that a new experimental nurse training scheme, not based on a single hospital, should be discussed with the General Nursing Council; that all nurses working in the service should have special ‘house-parent’ training or experience, and that staff with special training in residential care should work both in the community homes and in the hospital units in the community;

(iii) that the hospital and local authorities should jointly appoint a whole-time organiser of voluntary services whose task would be to stimulate and recruit individuals and organise voluntary participation in supportive services in hospitals and in the community and generally to co-ordinate the available voluntary effort so that it is used most effectively.

Before coming into this type of residential care the majority of children will have lived at home, but some may have been with foster parents, in a residential nursery or children’s home. A proportion of the first admissions will have been drawn from existing institutions. In future most of the children will have attended nurseries or be drawn from Group A residential accommodation for children.

Between the ages of 5-16, full-time residential care may be required for most, but for some a 5 day per week basis with a return home at weekends will be possible. The need for temporary care of children living at home during parents’ holidays will be met.