Teamwork for the mentally handicapped

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The last decade has seen a great deal of public and governmental interest in the mentally handicapped, culminating in Command Paper 4683 “Better Services for the Mentally Handicapped” in June 1971. Implicit in the title is the notion that present services are not as good as they should be. Most people working with the handicapped would agree that this is so, although a sizable minority remain surprisingly complacent.

The main objectives of any service for the mentally handicapped should be to help the handicapped person to achieve maximum independence, and to help their families to cope with the heavy burdens which they carry. There has already been a move away from purely custodial care in hospitals towards a more therapeutic approach. Over the next twenty years this will become easier, as increased community facilities of all kinds become available, thus relieving the present hospital overcrowding. Alongside the development of residential provisions, increased family help will be provided, both from Social Services and Education Departments on the local authority side, and from nurses, therapists, and doctors on the hospital side.

The need for co-operation

In order to help the mentally handicapped and their families to the utmost, the keynote for success will be close collaboration and co-operation between the three services – hospitals, Social Services, and Education – which provide residential care for the handicapped, and help for families at present. The time for complaining about each others’ shortcomings is over; and now we need to think positively about making co-operation work. There are various ways in which this can be done.

Informal links

At an informal level, community social workers should be encouraged to come into hospitals, to attend out-patient clinics and contribute to case conferences. Nurses equally should go into the community more, visiting the homes of mentally handicapped people, and following up those who have been discharged from their care in hospital. In these ways, the workers at grass-root level will gain a better understanding of each others’ difficulties, and this will lead to a closer working-together. This cooperation will be made easier when hospitals become fully aligned with their catchment areas. Regular meetings between social workers, nurses and doctors to discuss, for example, the progress of hospital residents who attend training centres in the community, are also useful in promoting collaboration in care.

Formal collaboration

At a more formal level, the establishment of joint working parties and of community teams would provide machinery for collaboration.

A joint working party between representatives of the Regional Hospital Board, the Social Services Department, and the Education Department must have the right people on it – those people who have sufficient authority to take the necessary decisions. A good chairman is also essential. The aims of the working party should be to formulate a generally acceptable overall policy, to take decisions about the kind of provisions which should be made by each service, and to set very firm target dates for the completion of these facilities. The investment of time and money in such working parties is fully justified,
because gradually an overall pattern for the provision of services will emerge, and each of the three bodies concerned will be able to see clearly where their responsibilities lie. As soon as this point is reached, the information should be passed 'down the line' for discussion at all levels within and between the three services. Everybody will then be able to see where they fit into the overall scheme of things. Insecurity will be avoided, and active planning can start.

Community teams

The function of a community team would be to provide maximum help to the families who keep their mentally handicapped member at home. In the midst of talk about overcrowding in hospitals, it is often forgotten that there are many more severely handicapped people (particularly children) in the community than in residential care. The social, physical, emotional and financial burdens of their families are well known. Perhaps their most basic need is to know that somebody cares about their problem - that they are not going to be left to deal with it alone. Yet even today there are socially isolated families with a mentally handicapped member who get very little help from any agency.

A community team might consist of a health visitor, a hospital nurse, a physiotherapist, a speech therapist, an occupational therapist, a social worker, a teacher, a psychologist, an administrator, and a doctor specialising in the care of the mentally handicapped. Their base would be in a hospital initially but, as the work-load of each team-member increased, they could move to a base in the community which they are serving. A register of all mentally handicapped children and adults would have to be compiled: and every family involved should be made aware of the service which is available. A single telephone call should be able to bring help when it is needed.

Of course, every member of the team would not descend on the home like a detachment of the Household Cavalry. The specific needs of the family would be identified by the health visitor, social worker or doctor, who could then ask the appropriate team-member to visit. Such a team would have access to residential facilities for short-term care, and regular team-meetings would be held to discuss on-going problems and general policy.

Such a team would not only help in promoting co-operation between workers from the different services. It would mean that the present hospital-type services could be delivered to the home, and the parents could be shown how to actively participate in helping their child to achieve as much independence as possible. Parents want to learn about positive things they can do, from simple exercises to behaviour-modification. Only a team representing several disciplines can do this effectively. And once a multi-disciplinary team is really in action, new ideas for care develop all the time.

Resources needed

Fruitful collaboration between the hospital and local authority services, to help the mentally handicapped and their families, is not only essential but achievable. Many people providing the service will need to learn new skills and greater flexibility: but, with proper training and leadership, these will develop. However, more resources will be needed to make co-operation a practical reality.

At present, case conferences and assessment meetings tend to be rather academic exercises, because of the lack of alternative provisions to hospital care in most areas. This is not to say that joint conferences should not continue: it is only when each side realises the pressures on the other that further provision will be made. But a range of provisions in the community is essential, so that the mentally handicapped person can be placed - for either short or long term care - in the facility most suited to his needs and abilities.

Hostels, or homes, in the community will have to be increased, but the time taken to draw up plans, find sites, and recruit staff makes these a medium-term proposition. In the short term, boarding-out and fostering schemes could be developed on a wider scale. The use of council houses, with a warden living in an adjacent house, should also be considered. These provisions could be promoted quite quickly, they are cheaper than either hostels or hospitals, and above all they allow the previously institutionalised person to 'grow'. For those who have never been hospitalised before, the transition from home to a boarding house would be less traumatic than the move from home to an institution.

The next resource required, however, is a big increase in the social work staff employed by local authorities. The social workers already have so much to do that they can only spend about 10% of their time with the mentally handicapped and their families. To operate the boarding-out schemes efficiently takes a lot of social work time: the right people have to be found, they have to be encouraged to do the work, and then given a lot of support if they are to continue. With the geriatric and mental illness work-loads increasing all the time - apart from all
their other commitments – the Social Services Departments cannot devote enough time to mental handicap. Here perhaps is another opportunity for co-operation between hospitals and local authorities. Could not nurses, as well as following up their discharged residents, also develop and support some community projects? The sooner people start working together, the sooner will new and better ideas emerge.

Hospitals need new resources too, as well as better management of those they already have. Many buildings are totally unsuited to the development of a therapeutic milieu, which should be the goal in caring for the mentally handicapped. Some hospital provision will always be necessary, and deliberate policy decisions should be taken now about which buildings can be improved by upgrading, and which need to be bulldozed. The siting of new hospital buildings – in units of 100-200 beds – should be determined now, linking in with the local authority’s proposed developments – a job for the joint working party.

Hospitals need more staff too – more nurses or care staff, more people from all disciplines. ‘Multi-disciplinary teams’ can only work if we have many different disciplines involved. But, at a more basic level, one nurse often has to look after 20 severely mentally handicapped people at any one time on a hospital ward or villa. Individual interaction is bound to be limited: the ones who receive the nurse’s attention are those who misbehave. ‘Wrong’ behaviours are thus rewarded, and become self-perpetuating.

Social training facilities need to be increased in hospitals as a matter of urgency, to prepare more mentally handicapped people for life outside the institution. The potential of so many hospital residents is not realised until they are placed in a good training situation. Sending people from hospital to training centres in the community is valuable, both as an exercise in co-operation and for the handicapped themselves. But most training centres are already bursting at the seams with those who live at home, and they tend to concentrate on work rather than social training: so more provisions need to be made for social training in hospital, as an interim measure.

**Some remaining problem areas**

Even with more adequate resources and better co-operation between hospital and local authority
services, certain problems will still need to be resolved. The roles of the doctor, the nurse, and the social worker will need to be considered in depth; although many new insights develop when the disciplines work together in teams. The doctor in mental handicap must be flexible enough to realise that the team can function well with him as a member, but not necessarily always the leader. He must welcome co-operation and advice from colleagues in other branches of medicine: he must encourage ideas and suggestions from colleagues in other disciplines.

The Briggs Report recognises that the nurse's role in mental handicap is changing, and that more emphasis must be placed on the social aspects of their work. This approach is right, and if the time comes when fewer care staff are needed in hospital, they will be able to transfer their skills readily into the community. Nurses should start looking outwards from the hospital, and taking every chance to see the problems in the community.

As far as mental handicap is concerned, the role of the social worker should be that of practical helper and adviser. Many families who appear to need case-work would not require it if they had practical help at the right time.

When professional workers develop the skills which enable them to pull together as a team, the boundaries between roles become blurred anyway: and the members of each individual team gradually come to define their own roles in relation to the mentally handicapped person and his family. Once teams begin to function effectively, the clarification of roles should no longer be a problem area. Teachers, physiotherapists, speech therapists, and occupational therapists all have an important part to play in the proper care of the mentally handicapped, and their contribution is clearly defined.

One problem area which deserves consideration relates to the staff in community homes. Many wardens feel isolated and deprived of adequate support. Houseparents become discontented after a time because of the lack of a definite career-structure. Continuity of care-staff is important for the well-being of the mentally handicapped people in these homes: and the number of homes will increase. Courses for wardens before they take up their posts, an effective support-system, in-service training and a career-structure for houseparents will all have to be developed.

The service we give to the mentally handicapped and their families should be very much better in 20 years' time than it is now. Improvement will depend on co-operation between the different services involved. Co-operation, in turn, will depend partly on the provision of more resources. We cannot get many nurses out into the community now, because the people in hospital would be even more deprived than they are already. We cannot get many social workers into the hospitals, because the community service would suffer more than it is suffering already. And we cannot move people out of hospital until there is somewhere for them to go.

However, co-operation depends too on flexibility, a willingness to work together, and goodwill. These features seem to be more in evidence at present - to end on a note of cautious optimism.