NURSING AND CARE IN MENTAL HANDICAP

The College's Comments on the Jay Report*

1. There are many positive suggestions made in this Report which, if carried out, would be of benefit to the mentally handicapped and their families; in particular the following:

(a) increased financial resources to be made available.
(b) doubling of the staff available for the care of the mentally handicapped.
(c) increase in residential facilities in the community for the mentally handicapped.

2. The recommendations are based upon a 'model of care' which is described in Chapter 3. Its main components are that virtually *all* the mentally handicapped should live either with their families or in small homes in the community.

3. The other main recommendation in this Report concerns staff training. The recommendation made is that the Certificate in Social Services (CSS) would be the appropriate qualification.

4. The College feels that there are serious shortcomings in this Report which may derive from the fact that the mentally handicapped are not seen as the very heterogenous group that they are, and in particular the special requirements of the severely handicapped, those with multiple handicaps and those behaviourally disordered do not receive the consideration they merit. There is also the feeling in this Report that hospitals are quite unacceptable and that institutionalization, isolation and a counter-productive hierarchical structure are unavoidable concomitants of hospital life and are somehow missing from community settings. There is also the assumption that hospitals are automatically not part of the community and that hostels are. The College feels strongly that the hospital is an essential part of total community care.

There seem to be a number of difficulties which this Report does not deal with, viz.

5. *Differing needs of a hetergenous group*

As the mentally handicapped are a heterogenous group with widely varying needs it does not seem likely that a single model of care could be appropriate. More specifically, there are the mentally handicapped who have varying combinations of the following difficulties:

—serious illness e.g.
epilepsy
muscular disorders
sensory defects
mental illness
—non ambulant patients either in wheelchairs or bedridden.
—dying patients.
—behaviour disorders, e.g.
aggression to people and/or property
self-injurious behaviour
bizarre types of behaviour
deviant behaviour, including stripping, sexual misbehaviour (towards children, and strangers)
unhygienic behaviour.

Neither these behaviour disorders nor methods of dealing with them are properly considered in this Report. Throughout, the rights of the mentally handicapped are stressed but little is said about their responsibilities or about the rights of their families and other people to be protected from disturbed behaviour and from the small number who have violent or criminal tendencies. The special categories listed above could not be cared for adequately if all services were based on small units staffed by people with CSS training.

6. *The needs of the mentally handicapped*

The needs of the mentally handicapped are not discussed in detail, nor are methods for meeting them analysed. The assumption seems to be that a comfortable, homelike setting in a small group is sufficient. In practice, if the lot of the handicapped is to be improved, their needs must include the following:

(a) Facilities for diagnosis and assessment, i.e. special investigations, psychological testing, behavioural observations, elucidation of family background, genetic and other factors. Assessment is usually a prolonged process, which may take months and should be carried out in a situation where skilled doctors, nurses, occupational therapists, physiotherapists, psychologists, speech therapists and teachers are available.

(b) Residential facilities should be homelike, but should also provide skilled medical treatment, behaviour modification, vocational help, social training, training in self-help and other skills, as well as recreational facilities. It is not realistic to suggest that the mentally handicapped need 'normal' facilities; they need facilities suitable for their particular needs. No consideration of facilities is complete unless it is based on research into aetiology and prevention as well as into treatment and quality of care.

7. *Limitations of small group homes*

Small group homes have many advantages but they also have disadvantages, viz:

* Prepared by the Special Committee which drafted the College's evidence to the Jay Committee, and approved by Council. The members of the Special Committee were Drs W. A. Heaton-Ward (Convener), Valerie Cowie, Diana Dickens, H. Hunter, W. R. McKibben, D. Primrose, A. Shapiro, C. E. Williams and P. G. Woolf. Dr J. Jancar attended the last meeting, and written comments were received from Drs J. Corbett, M. Leyshon, B. I. Sacks and R. Veall.

https://doi.org/10.1192/S014007890000554X Published online by Cambridge University Press

i Difficulty in getting the social mixture correct, and in offering large selection of residents and staff in order to develop social relationships.

ii Difficulty in reducing the inevitable tensions in small units.

iii Difficulty in providing good and varied staff; mutual staff support may be lacking because of the small numbers involved.

iv Staff supervision is much more difficult than in open units in which many people are involved. By the same token scrutiny of standards of care is difficult. It is naive to suppose that local authority units are not liable to the abuses that have been publicised in some hospitals.

v Small groups would have logistic problems, particularly as regards transport.

vi Difficulty in providing training and recreation—especially for those who are unsuitable for adult training centres or work. In practice local authority homes accept only those who are out during the day. If residents are unable to get out they are unlikely to receive any therapy while they remain in the hostel.

8. *Community acceptance*

The assumption seems to be not only that small group homes in 'the community' are the best place for the mentally handicapped to live in, but also that 'the community' will easily accept them. This view ignores some of the following factors:

i Units in 'the community' find that the tolerance of their neighbours wears thin when violence, deviant sexual behaviour or bizarre behaviour are exhibited.

ii There seems to be a saturation level for community placements even when relatively acceptable mentally handicapped people are involved.

iii Community hostels almost all tend to be built in less salubrious neighbourhoods.

iv Many mentally handicapped are vulnerable to the stresses of life—they are inevitably exposed to more of these in community settings, and many find these stresses intolerable.

v Most of the comparisons made between hospital and hostel facilities are misleading because, in general, the hospital population have more serious handicaps than the hostel population.

9. *Problems of local authority administration*

It is suggested in the Report that the small group homes should be administered by the local authorities. This may be a cause for concern because the past record of many local authorities in this field is poor, and the care of the mentally handicapped has almost always received low priority in local authority politics. It would seem difficult for local authorities to provide the supporting and supervisory structures needed for small group homes.

10. *Inadequate training*

There is an assumption that there is a great pool of people waiting in the wings to care for the mentally handicapped. Those of us in clinical practice know this is not so and that in fact it is extremely difficult to staff community units even when these are in the middle of housing estates which would appear to be affluent in potential manpower. At present, Social Services Departments depend heavily on the hospital service for assistance with those with disturbed behaviour who may be accommodated by their families but cannot be accommodated in hostels.

The model of care leans heavily on the recommendation that the training of mentally handicapped residential care staff should be under the aegis of the CCETSW. The College is unconvinced that the CSS is an adequate training for the full range of mental handicap care. The type of person able to cope both emotionally and physically with the behaviour of the disordered and those with multiple handicaps needs to be very different from the type able to look after the mildly handicapped. The College can see no basis for advocating a generic type of training producing a person who cares for the whole spectrum of handicap. The suggestion that one year at the end of normal residential training would be enough to equip staff to cope with the mentally handicapped is completely unrealistic. There is an increasing proportion of profoundly handicapped people who cannot benefit from a community setting and require nursing care in hospital. The profoundly mentally handicapped are unable to communicate about their disease and distress, either mental or physical, and highly skilled and trained nursing specialists are therefore needed to recognize illness and symptoms so as to be able to nurse these patients adequately. It was the recognition of this need that led the Royal Medico-Psychological Association, in the first quarter of this century, to introduce special nurse training in order to obtain these specialist qualifications.

While welcoming the development of training for the CSS along the lines proposed in the Report, the College strongly supports the retention of the RNMS and RNMD qualifications until it can be shown that possession of the CSS diploma represents evidence of training to deal with all aspects of care of the mentally handicapped at least equal to that provided by possession of the present specialist nursing qualifications. The College suggests that the GNC and CCETSW should set up a joint working party to consider future training and the possibility of setting up an experimental course. Meanwhile, nurse training should continue to be hospital-based, but extended to include modules of community care.

11. *Legal aspects*

The legal aspects of care are not considered in this Report, e.g.

(a) Where compulsory admission is needed for the safety of the patient and/or others, and how this should be followed up.

https://doi.org/10.1192/S014007890000554X Published online by Cambridge University Press

(b) The need for statutory reviews of all mentally handicapped persons in residential care.
(c) The fact that most legislation concerning local authorities is couched in permissive terms, whereas the needs of a non-vocal group with little political importance, such as the mentally handicapped, can only be protected by mandatory legislation.

12. *Conclusions*

In general it seems that the following comments can be made:

(a) the 'model of care' described is more an expression of how the mentally handicapped ought to be than of how they actually are.
(b) the fact that institutionalization, rigid hierarchies and abuses can occur in small community units as well as hospitals is ignored.
(c) the important distinction between custodial care and therapeutic intervention is largely ignored.
(d) at present many patients are in hospital because they have been rejected by their families and/or 'community' in the first place.
(e) the suggestion that what is right for the most able mentally handicapped is also right for the most severely handicapped denies the real needs of the latter, with the inevitable consequence that they will suffer, money will be wasted, staff become disillusioned, and the experience of staff and existing structures will be lost. It is always easier to destroy a system than to build one.
(f) Experience has often shown that when the mentally handicapped are excluded from hospital care many do badly and they and/or their families insist on re-admission very soon after.

The denial of many of the real difficulties in treating the mentally handicapped can only lead to false hopes and inevitable disillusionment.

The College does not feel competent to comment in detail on the Report's recommendations on manpower and organization for staffing of the Social Services residential units as such. However, it considers that the amount of finance necessary to implement these recommendations is unrealistic and unobtainable at this time of economic restraint. Had it been made available in the past it is arguable that it would not have been necessary to appoint the Jay Committee.

LOCKED WARDS AND INFORMAL PATIENTS
Opinion of the Public Policy Committee

The College has since its inception, and previously as the Royal Medico-Psychological Association, been concerned with the freedom of the individual and the importance of preserving the individual's rights. The College has been instrumental in helping to bring about the policy of open doors in psychiatric hospitals.

In 1977/78 enquiries were made of the College by the press and others as to the nursing of patients, and especially informal patients, in locked wards. This matter was referred to the Public Policy Committee which instituted an inquiry on this matter through the College Divisions.

It was not possible to comment on specific responses to the inquiry, nor concerning specific instances raised by the press, because of the wide variation in local circumstances. However, it did seem that in some areas there had been a small increase in the locking of wards, particularly those caring for the elderly who would wander; situations involving the presence of younger patients sent by the Courts; and also at times where, because of fluctuations in available staff (caused by sickness, problems of recruitment, etc), adequate supervision and care could not be provided in an open ward setting.

However, the Committee considered that certain general statements could be made:

1. Many patients nursed in closed wards can visit other parts of the hospital; can go out for a few hours and can go home for weekends. This applies to the 'compulsorily detained' as well as informal patients nursed in a closed ward.
2. A closed ward gives some patients a greater feeling of security, and this should not be underestimated.
3. A closed ward can give staff the opportunity of better supervision and control of patients and for varying their activity in response to changes in their clinical condition.
4. While many hospitals find it essential on clinical grounds to have one or two closed wards, there has been no change in the general philosophy that wards should remain open wherever possible. Thus nearly all wards in a psychiatric hospital are open wards.
5. Any decision to close a ward should be made on the basis of treatment and management needs and centred on the needs of the patient or patients.
6. The Committee strongly recommends that a decision to close a ward should only take place under well defined procedures. While theoretically the closure will be authorized by the responsible medical officer the procedures are best drawn up by discussion between team members so that doctors, nurses and others are brought together in facing this difficult problem and working out the necessary safeguards. For instance, certain emergencies might lead to the need for a nurse to close a ward