Comment on 'Mental Handicap: Policies and Priorities'

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The mental handicap scene is changing but not as quickly as some would like. A constant stream of letters, consultative documents and booklets remind us of the various ways in which we can work together to create a service where the health care component is rationalized and the large hospitals are reduced in size. The services are changing, but there is variation in the pace of change and in the commitment to the joint planning process involved in such change.

In 1971 the first of the major documents was produced[1] with detailed statistical data which is still being used in the planning process. Nine Years later the DHSS produced a review of progress[2], redefining some of the targets. *Care in Action*[3] and finally, *Care in the Community*[4] increased the impetus for change in the direction of community care.

I suspect that change occurs in one of two ways: either fieldworkers identify a need and convince the planners to find resources to meet that need or the ultimate planners and financial managers of the service direct change as a result of national review and knowledge of norms. The latter form of planning involves the passing of a message down the chain of command, and *Mental Handicap: Policies and Priorities*[5] is such a document. The DHSS ask the Regions to prepare for the Regional Review when they must give account of themselves, by taking note of the current priorities and acting on them as far as possible. The message concerns in particular the removal of children from long-stay hospitals and the provision of funding to do this, the appropriate provision of day services, the development of community care, the reduction in size of large hospitals and the development of services for those mentally handicapped people with very special needs.

Two of these matters, that of the provision of day care and other services in which the special needs of those who are behaviourally disturbed or multi-handicapped can best be met, are at present being studied by a team from the Department and these reports should be available early in 1984. The provision of day care for profoundly handicapped people who live at home has often fallen into the hands of the Local Health Service, and for some this day care is provided by the large long-stay hospital. In other places day care facilities for smaller groups and in a community setting have been established. The role of Social Services in the provision of such day care varies, but there is now general agreement that special care units should be within the remit of Social Services and attached to Adult Training Centres rather than Health Service Facilities. It is, however, clear that joint planning of these services and working together is vital, making health care available in Special Care Units and Training Centres.

There will be some for whom community living is hard to maintain without intensive support from the Health Service. Mentally handicapped people with behaviour disorders, with additional psychiatric or complex medical needs must be able to turn to a resource that is adequately staffed, readily available and valued within the Health Service. There is continuing debate as to whether such resource should be from the 24-bedded community unit or a small 'base' or 'core' hospital and how much can be done on a domiciliary basis by Community Mental Handicap Teams. Specialist services may be provided in every District or a supra District Service meeting one specialist need may be complemented by a similar service meeting another specialist need in an adjoining District. It is likely that there will be a range of solutions throughout the country depending on the geography, the density of the population and local needs.

As it is accepted that hospitals need to contract and that priority is given to moving out mentally handicapped children into the community, some definitive funding arrangements are at present directed to this younger age group. Three million pounds has been put aside for each of the next three years to move children out of hospitals. As from 1982, the Government has been prepared to match on a £ for £ basis, funds raised by voluntary bodies for the same purpose.

It is still open to DHAs to make annual payments to Local Authorities and Voluntary organization for individuals of any age moving into community care, and an extension of joint financing schemes and a programme of pilot projects, costing up to £15,000,000 of centrally reserved joint finance funds, should help those of all ages to move into the community.

The document ends with four key issues: the running down of large hospitals and the development of District based services: the need to move children out of hospitals; the recruitment, training and deployment of staff; and, above all, the need for collaboration and joint planning between the respective agencies involved in the provision of a total spectrum of care.

The Regional Health Authorities received this document as an aid to planning and as a distillate of the many documents produced hitherto. Regions will pass the message on to DHAs who will translate this into the local scene. It is hoped that neither the strength of the message nor the urgency of implementation is lost in this process of devolution.

Mentally handicapped people have a right to housing, to appropriate education, to social services and health care and, above all, to citizenship. There is much to put right and to meet the directives of this paper will require hard work, co-

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operation and a vision of a different future for mentally handicapped people whose lives are so often and so inappropriately in the hands of the medical profession.

References

[1]DHSS (1971) *Better Services for the Mentally Handicapped*, Cmnd 4683,

[2]—— (1980) *Mental Handicap: Progress, Problems and Priorities. A review of mental handicap services in England since the 1971 White Paper.*

[3]—— (1981) *Care in Action: A handbook of Policies and Priorities for the Health and Personal Social Services in England.*

[4]——(1981) *Care in the Community: A Consultative Document on Moving Resources for Care in England.*

[5]——(1983) *Mental Handicap: Policies and Priorities.*

Infant Psychiatry: Developments

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Developments in preventive psychiatry should occur as a result of new knowledge of the psychiatry of infancy as presented at recent conferences: the International Conference of Child and Adolescent Psychiatry, Dublin 1982; the World Infant Psychiatry Congress at Cannes, March 1983; and the Child and Adolescent Psychiatry Congress in July 1983 at Lausanne.

Many papers describe the very early perceptual awareness of infants, their in-built cross modal abilities and the fine rhythmic relationship between mothers and their babies. In the US, 32,000 feet of film was run on 20 normal new-borns, indicating the intensity of work with infants these days.

At the Dublin Conference, findings concerning the 'attachment' and 'bonding' relationship with mother and augmentary caretakers were described by Levine on the psychobiological level revealing cortisone as the most sensitive indicator of a stressful situation and ameliorating support of the caretaker. Many papers described the state of confusion of babies when overwhelmed by stimuli, followed at a later age by withdrawal or attack. Sudden alteration in mother's facial expression can lead to these reactions—'a lack of response face'. The baby's heart rate responds in a discriminatory manner to touch by mother rather than stranger.

Crying is but one of the ways a baby may signal distress. Of 100 cases referred to our child psychiatry clinic (paper presented in Dublin), children with neuroses were described by mothers as 'crying babies', and those with behaviour disorders and psychosis as 'non-crying'. Mothers of crying babies failed to use the pacifier; mothers of non-crying babies also denied problems in themselves—indicating the interactional nature of the situation. Medical records in the main supported mothers' histories.

The import of early contact experienced by mothers and babies shortly after birth was stressed in a number of papers, and the therapeutic use of 'holding' described. Parental homework—the holding of autistic children—appeared to be of considerable value, according to a number of studies.

Following the work of Klaus, who described mother/baby contact for the first hour as leading to better interaction at age 5 years, de Chateau presented his recent work at the Cannes Conference indicating that by 3 years of age some of the positive effects in the index group above the control group had lessened, but there were biochemical changes and continuing favourable effects of the early contact. Since Klaus's work there have been many studies indicating the long-term favourable effects of early contact; others denying the permanence of these effects. Our recent study indicates that by age 6 weeks at developmental check-up, those mother/baby couples having had half an hour or more contact after birth had fewer problems than those with 5 minutes or less contact, or those having had a caesarian section or anaesthetic, etc, which necessitated mother/baby separation for half an hour or longer (Lausanne, July 1983). 'Holding' was found to be the commonest cry cure.

The great value of mother/baby units was described by French psychiatrists as serving 'a supportive grandparental function', and babies rarely needed removal from mothers with psychiatric disorder.

It is impossible in a short summary to discuss the very many interesting papers of well known authors, including Anthony, Hinde, Papousek, Brazeldon, Kennell, Bowlby and Stern.

Apart from early stress relief, infant psychiatry research is also of value in the treatment of already stressed individuals in childhood and possibly also in adult life, e.g. the value of holding autistic and hyperactive children. Knowledge of the minutely detailed interactive rhythms between babies and mothers in the earliest period should have repercussions concerning support services in maternity and paediatrics, and indicates the relevance of infant psychiatry to all age groups.