King's Fund Centre

MENTAL HANDICAP PAPERS

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ADULT EDUCATION FOR MENTALLY HANDICAPPED PEOPLE

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"If you are young, don't wait until you and your handicapped child are older - beg everyone, everywhere, right now, to understand what your child will be facing when he is 16 years old. Whilst he is young in years, there is sunshine, love and brightness, but what a cruel shock, when he has to leave school on his 16th birthday and become overnight an adult. Everything is finished. It's like switching off a light."

Advice from the mother of a
severely handicapped young man

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ADULT EDUCATION

FOR

MENTALLY HANDICAPPED PEOPLE

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CONTENTS

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INTRODUCTION

One fundamental aim of education is to help people to develop their own potential, within a changing society. This aim applies to mentally handicapped people, just as to anyone else. But although the aim may be the same, the opportunities are often different.

There is ample evidence that mentally handicapped people, given the right educational opportunities, can achieve much more than most people would believe possible. Unfortunately, they tend to be sheltered from or excluded from life's experiences. Yet it is mainly these very experiences which will help them to learn and develop.

Education must aim to build up confidence in mentally handicapped people so that to the limits of their ability they may acquire the ordinary social skills, and acceptable behaviours, which seem to come naturally to other people. Then they can begin to share in life's experiences, to enjoy life more, and to realise their own unexpected qualities.

But however well the education system pursues this aim, mentally handicapped people will not become involved with ordinary life if they are continually faced by ill-informed, frightened or antagonistic people. So ordinary people need to learn about the needs of mentally handicapped people, and how, given a chance, their potential can be realised.

This discussion paper is designed to show how the general Further Education system can help the twin processes of developing the mentally handicapped adult and informing the general community.

* * *

1. WHY WE MET

1. Further education may not seem a particularly appropriate service for mentally handicapped people, except perhaps for a select few. At the outset, the organisers of this working party themselves assumed that what they were looking for was a list of appropriate subjects, like reading or cookery: it was not until after the first meeting that some of the members realised that what we were considering was not a simplified edition of the normal curriculum, to be administered in formal classes, but the allround development of the mentally handicapped adult; and that this is, or should be, the principal aim of all who provide services for mentally handicapped people.

2. The Russell Report on Adult Education [1] offers a wide horizon of what might be achieved in the field of adult education, particularly for people in minority groups, including those with mental handicap. Preliminary enquiries by the King's Fund Mental Handicap Project indicated that whilst some subnormality hospitals were taking advantage of local further education facilities, and whilst some mentally handicapped people living in the community were being guided in that direction, far too many opportunities were being missed.

3. The Fund therefore decided to invite a group of people to help in the consideration of this topic. Their names, listed elsewhere in this report, are an indication of the wide spectrum of interests represented. The group itself sought the advice of a number of voluntary agencies; and we had the revealing experience of an afternoon's discussions with an articulate group of parents of mentally handicapped people: these parents humbled us by their insights and by the sense of humour with which they were able to perceive their own difficulties. We were very happy to take a number of their suggestions into account in preparing this discussion paper.

2. THE OBJECTIVES OF THE SEMINAR

4. At the outset we felt that three main questions needed to be answered. To what extent can mentally handicapped adults benefit from the extension of educational opportunities? What is the best way of providing that education? How can mentally handicapped adults be helped in this direction?

5. These questions reveal an over-simplified view. When we began to discuss our programme we found that the subject was much more complex. We had to consider the general philosophy of the development and motivation of mentally handicapped people. We had to consider the range and quality of many existing services, which undoubtedly constitute further education though not always under its official banner, and which often appear in unlikely places, afforded by unlikely people. We had to understand the purpose and objective of the general further education system before we could even consider whether it was relevant for mentally handicapped people. Another big problem was to decide who ought to be providing further education opportunities: should the effort be limited to those employed by education authorities, or could other people participate with advantage? It began to be clear that even those people whose skills lie in education might still need extra training or induction to enable them to shape their skills to help the mentally handicapped. We became aware of severe and continuing problems of co-ordination between the health service, social service, and education service on the one hand, and families and voluntary organisations on the other. We had to face the fact that though further education need not be capital-intensive it still costs money, and authorities controlling education funds would need to be motivated to a better understanding of the needs of mentally handicapped people. We began to see that whilst handicapped people as a whole are a minority who have not received enough attention, mentally handicapped people are a neglected group even within that minority.

6. Our most significant early insight was to realise that there is in fact a gap: those who care for the mentally handicapped are not always aware of the full possibilities of the further education service; those who provide further education are not always aware of the degree to which mentally handicapped people can benefit by further education. We began to see it as the main task of our seminar to close that gap.

7. Our hope is that this discussion paper will be considered by all who come into contact with the mentally handicapped, whether they live in hospitals, in hostels, in group homes, or in their own homes; and by all who are involved in education - be they in colleges of further education, adult education centres, adult training centres, or in special schools. We have come to believe that a considerable advance can be made, if only the two groups of people - providers and consumers - in their local situations, will consider the facts we have tried to identify, and will then work together to close the gap.

3. DEFINITIONS AND PRINCIPLES

8. Since the gap between the further education service and mentally handicapped people may be partly due to lack of awareness, we propose to provide some definitions. These come in the language of official reports but they present a useful framework on which to develop the argument on later pages of this report.

9. Firstly, as to adult education, a concise specification of needs for adult education is listed in paragraphs 57 and 58 of Adult Education: A Plan for Development. (1) The paragraphs are given below by permission of HMSO and particular attention is drawn to paragraph 58(2) with its comments about those who are handicapped or otherwise disadvantaged. This gives us a picture of adult education which may not be familiar to those whose job it is to care for the mentally handicapped.

"A Specification of Needs for Adult Education

57. Adult education, being an activity voluntarily undertaken by responsible persons out of motives derived from their personal lives, must necessarily touch life at many points. There can be few aspects of life to which education has no contribution to make and it should not be surprising that the range of needs outlined in the foregoing sections is so extensive. Yet we make no claim that the list we have given is comprehensive. Others will no doubt be able to add to it. The items moreover are not mutually exclusive: a number of different needs will coexist in any individual at any time. The list derives mainly from the great body of evidence that has been presented by large numbers of individuals and organisations, supplemented by our own extrapolations into the future.

58. Nevertheless, if an assessment of needs is to be made the basis of a system of provision, then priorities, involving value judgments, will have to be established. No doubt some of the needs we envisage are capable of satisfaction by commercial enterprise and others by the independent action of individuals. Moreover needs change as circumstances change and the satisfaction of one need may lay the way open for others to appear. The following summary is designed therefore as a pattern of ascertainable needs upon which an evolving system of adult education could be based, concentrating on those which cannot be met by an individual acting on his own and those which enable an individual to play his part, in the most fully developed way, in a free and democratic society. It will have been evident, in this latter connection, that in most of the areas of need we have discussed, the relative disadvantage of one group as compared with others has been a central feature.

58.1. We can identify those needs that are related to the functioning of the education service and particularly to the goal of equality of educational opportunity. By this we mean equality of opportunity for each individual actually to benefit, according to his personal capacities, from the total range of educational provision, and not simply to compete for its benefits, which is what equality of opportunity has often meant in practice. To this extent we are in

accord with the concept of "permanent education". These needs may be summed up as follows:

58.1.1. Remedial education, or the completion of the schools' unfinished tasks. There will be many levels of this, from basic literacy upwards.

58.1.2. Balancing education: that is, filling in the gaps left by the inevitable specialisation of schools and colleges.

58.1.3. Second-chance education, or the opportunity to acquire qualifications whose relevance to the individual has become clear in adult life. The term "second-chance education" has gained currency, but it is not to be interpreted strictly: the need may equally be for third, fourth or nth chances.

58.1.4. Up-dating, or the opportunity to keep abreast of developments in fields where knowledge is rapidly expanding.

58.1.5. Education about education, or the planned promotion of an educative environment, in and around the family home, at work, and elsewhere, which will support and reinforce the work of the schools and colleges and not run counter to it. There can be no true system of education without this.

58.1.6. Counselling and the clarification of choices. There are two related needs here: for information about the range of educational opportunity provided and for help to an individual in assessing his own objectives and capacities in relation to those opportunities.

58.2. Then we can identify those needs that are related to individual personal developments: for example:

58.2.1. Creativity, or the opportunity to fulfil oneself in creative activity of many kinds, ranging from the arts, like painting and three-dimensional arts and crafts, music, drama, dance, speech and writing, to problem-solving, mathematics and scientific activity.

58.2.2. Physical activity, especially the cultivation of skill in recreative pursuits, games and outdoor activities.

58.2.3. Educative social activity, or the opportunity for self-discovery and self-expression in groups of common interest. The health and vitality of local communities may depend as much on the meeting of this need as upon any other single form of activity.

58.2.4. Intellectual activity, towards which all other forms of education are likely to act as a stimulus.

Those who are handicapped, disadvantaged, in hospitals, prisons or otherwise prevented from engaging in the general provision of adult education will, in most cases, have the personal needs identified above and will also have particular needs related to their circumstances, including the need to be helped towards re-integration into general society.

58.3. There are those needs that are related to the place of the individual in society: for example:

58.3.1. "Role education", directed not to training for qualification but to providing the background of knowledge, especially in relation to social change, through which the individual's role can be more responsibly discharged in society, in industry, in voluntary service or in public work of any kind. Here again there will be many forms: examples are education for magistrates or policemen for clergy or social workers, for shop stewards and trade unionists, for managers and local government officers.

58.3.2. Social and political education of very broad kinds, designed to enable the individual to understand and play his part as citizen, voluntary worker, consumer.

58.3.3. Community education, or providing the background of knowledge and understanding upon which effective action for community purposes, including community development in the strict sense, can be founded.

58.3.4. Education for social leadership. One of the prime needs here is for learning situations in which those with potentialities for leadership (including opinion-leaders) can discover themselves and try themselves out, rather than for set schemes that prepare and train leaders who have been selected in other ways."

10. Now for the other side. What do we mean by mental handicap? Are we speaking of people whose minds are a total blank, and who are not susceptible to stimulus or encouragement, colour or sound? Or are we speaking of a group of people who are like the rest of the world, but somewhat slower? Are we indeed speaking of a homogeneous group at all? Here our extract is from the pages of Better Services for the Mentally Handicapped - a government White Paper. (2)

"1. There are probably about 120,000 people in England and Wales who are severely mentally handicapped, of whom about 50,000 are children. Many more are mildly mentally handicapped.

4. The term "mental handicap" is used throughout this paper. Various other terms are used, here and in other countries, with the same meaning. "Mental deficiency" used to be the statutory term in England and Wales and still is in Scotland. In England and Wales the present statutory terms are "subnormality" and "severe subnormality", which together cover the conditions for which the term "mental handicap" is used in this paper. The term "mental retardation" is used in the United States and has also been adopted by the World Health Organisation with the sub-classifications "mild", "moderate", "severe" and "profound"; the last three of these together are broadly equivalent to the term "severe mental handicap" used in this paper. "Mental handicap" is used in preference to any of the alternative terms because this helps to emphasise that our attitude should be the same as to other types of handicap, i.e., to prevent it whenever possible, to assess it adequately when it occurs, and to do everything possible to alleviate its severity and compensate for its effects.

What is mental handicap?

7. A person who is mentally handicapped does not develop in childhood as quickly as other children nor attain the full mental capacities of a normal adult. The handicap may be slight or severe. In the most severe cases, development does not progress even in adult life beyond the mental capacity of a young child; such severe handicap is much less common than milder degrees of handicap covering a wide spectrum ranging up to and merging into the "normal".

8. Mentally handicapped people have difficulty in understanding, and in adapting themselves to new situations. They may find it difficult to communicate, or to establish relationships with more than a few people, but they are generally affectionate and respond to affectionate treatment as children do. Many of those with severe mental handicap have physical handicaps as well, which are often also severe; they find it more difficult than other people to compensate for even a minor physical handicap. Some of the mentally handicapped also suffer from mental illness or personality disorders. But often mental handicap entails no more than slow and restricted development, uncomplicated by any other serious disability.

What are the causes?

9. In most cases the causes are not known. Mental handicap can result from conditions arising before or at birth which affect the functioning of the brain; some of these are becoming rarer owing to improvement in the maternity services, but more children with very severe handicap are now surviving birth and infancy. It is often the result of unpredictable and unavoidable factors - hereditary or environmental or both - including the lower end of the normal range of variation of intelligence. In some cases the handicap is known to be due to an organic condition, such as a chromosome abnormality or metabolic disorder; in a few cases, some of these conditions can now be corrected if identified at an early stage.

Effects of other handicaps

10. Without very careful assessment, some children with disabilities of hearing, vision or language may be diagnosed as mentally handicapped because of their inability to communicate. Even when such a disability is clearly recognised, development may be delayed or in extreme cases permanently restricted, resulting in mental handicap, if the disability cannot be corrected or cured by special education or treatment. Some form of physical illness occurring in childhood may have a permanent effect on mental development and produce mental handicap.

11. A child's capacity to learn and develop may be restricted through social deprivation, particularly if the child or his parents are somewhat below average in intelligence; such children may improve remarkably if the emotional and intellectual stimulus of which they have been deprived can be provided.

Mental illness and mental handicap

12. Mental handicap is sometimes wrongly confused with mental illness. Mental illness can strike anyone at any age: it usually responds to treatment and can often be cured. Mental handicap, on the other hand, is usually determined before or during birth or in the early weeks of life and affects a person's ability to learn and reason. It cannot be "cured" in the same sense as an illness but the development of

mentally handicapped people can often be improved by education, training and social care (and without such help may remain unnecessarily restricted). The physical and emotional disabilities which are often associated with mental handicap may be alleviated with special medical, nursing and educational treatment.

Prospects

13. Although the handicapped have a shorter expectation of life than the population as a whole, the majority live well into adult life and many into old age. There are many more mentally handicapped adults than children. The severely handicapped never become fully independent but need special help throughout their lives. Those with milder degrees of handicap need varying degrees and forms of support. "

11. The White Paper referred to above embodied a set of principles, most of which are accepted by parental and governmental organisations alike, all over the civilised world. Of the fifteen principles listed as being those on which current thinking on mental handicap is based, the following are particularly relevant to this discussion document.

"40.(i) A family with a handicapped member has the same needs for general social services as all other families. The family and the handicapped child or adult also need special additional help, which varies according to the severity of the handicap, whether there are associated physical handicaps or behaviour problems, the age of the handicapped person and his family situation.

(ii) Mentally handicapped children and adults should not be segregated unnecessarily from other people of similar age, nor from the general life of the local community.

(v) Each handicapped person needs stimulation, social training and education and purposeful occupation or employment in order to develop to his maximum capacity and to exercise all the skills he acquires, however limited they may be.

(ix) There should be proper co-ordination in the application of relevant professional skills for the benefit of individual handicapped people and their families, and in the planning and administration of relevant services, whether or not these cross administrative frontiers.

(xi) There should be close collaboration between these services and those provided by other local authority departments (e.g. child health services and education), and with general practitioners, hospitals and other services for the disabled.

(xv) Understanding and help from friends and neighbours and from the community at large are needed to help the family to maintain a normal social life and to give the handicapped member as nearly normal a life as his handicap or handicaps permit. "

12. The basic legislation covering Further Education lies in the Education Act 1944 and in the Further Education (Grant) Regulations 1959.

4. THE PHILOSOPHY OF DEVELOPMENT AND THE CHALLENGE OF MOTIVATION

13. Mentally handicapped people need to discover something about themselves and something about the world they live in: their great problem is in adjustment to the ways of society. Further education could give them an opportunity for self-discovery and self-exploration; an awareness of, involvement in, and ability to cope with what is going on around them, to the limit of their disability. Their deficits cover the whole spectrum of experience: social, vocational, cultural and recreational. They have great difficulty in developing relationships with other people, sometimes due to their lack of skill. For example, it is not commonly realised that for all of us, even knowing how to use a knife and fork is an aid to communication, because with that skill, we can take our place inconspicuously in cafeteria or restaurant. Without it, a mentally handicapped person is reduced to using the wrong implements, or even his fingers, thus creating a visible barrier between himself and the rest of the world.

14. What adult education can do is to help the handicapped person to cope, to make relationships, to communicate; it can add to his pleasure, produce a challenge, and very important, develop his curiosity. What we would hope that adult education would do for the mentally handicapped would be to develop their knowledge, skills, judgment and creativity, throughout life, and increase experience and inter-action. There is a side-effect also: mentally handicapped people who succeed in adjusting to the ways of the community, give other people the chance to learn more about mentally handicapped people, their strengths and weaknesses.

15. The need for motivation is a continuous one: those helping the handicapped must for ever be trying to perceive the gap between the concrete experience and the development of ideas from it. There must be a constant search for assets. For example, a group of handicapped people from a large, old, mental subnormality hospital went to Majorca for a holiday. They took cameras and some cine equipment. When they returned to the hospital they had developed a little interest in geography, but a lot in cine and still photography. A perceptive member of the hospital staff linked them in with the photographic activities at the local college of further education: now they are members of a photography club. This is an example of the way in which staff need to see themselves, in all they do, as part of the action of stretching the mentally handicapped, mentally and physically, in an environment which affords varied and new experiences. At present, experience comes too much by chance: it is not sufficiently prescribed. Concrete experience must be exploited all the time, if it is to be integrated: it can be brought in to the day or residential setting, or better still, the mentally handicapped can go and see. What they need, if they are to be helped, is the verbal exploitation

of concrete experience: they need to internalise a model of what they have experienced; they need to talk to other people about things they have experienced. We need to learn to listen. If opportunities of this kind are available in addition to more formal classes, the fact will advertise itself among certain of the mentally handicapped. Many have a fair idea of what they want, and can state it. Others have an idea, but find it hard to express.

16. There are some minority groups among the mentally handicapped who need even more motivation than their fellows. These are people such as the deaf, the blind, those with speech difficulty, immigrants with no English. They constitute a largely unclassified mixture, whose educational needs are difficult to identify. Each of these people requires a clear prescription to meet his needs, once these are recognised. One certain effect of this will be that this clearer definition of needs will highlight the lack of staff, the lack of specialised resources, and the lack of knowledge of the techniques likely to prove effective. At a guess, the minority groups might form 10% of the residential population, but to meet their needs may call for 90% of the staff effort. The result of this is that these difficult minorities often get left until later, which can well mean never.

17. Mentally handicapped people need motivating even more than ordinary people, and this applies whether they live in hospital, or hostel, or at home. We must not attempt to categorise mentally handicapped people on the basis of IQ alone, nor by using terms such as 'high grade' or 'low grade': by labelling we predetermine: when the phrase 'mince is for the low-grades' is used, it often means 'it is easier and faster to feed large numbers with minced food'. The great danger of labelling is that the teacher (or co-teacher) expects a performance which lives down to the label: and the label tends to stick for life.

18. The way the offer of adult education is put is decisive. As with the rest of us, a mentally handicapped adult may resist the thought of going "back to school". If it works well, then we are likely to find, just as in general adult education, that a satisfied customer is the best ambassador. Because they are adult, compulsion is out: handicapped people have to be encouraged to come to drink from the stream. A young handicapped man of 21 years of age may regard cookery lessons as essentially for females. However, if he lives in a hostel where he has to cook his own breakfast, he may well be glad to go to cookery lessons after a week of corn-flakes. Timing is important. The time to learn to use a knife and fork is before or during dinner, but certainly not afterwards when the hunger motive has disappeared. Similarly, learning to use the loo has to take place before or during a motion, not afterwards when the need has passed.

19. Older parents have often been conditioned by older attitudes, and thus they may feel that continuing education, particularly in its informal aspect of experience-gaining, is too much for their son or daughter. The right of the mentally

handicapped person to be accorded the dignity of risk, in the course of pursuing educational opportunities, may well conflict with the wishes of the over-protective parent. Younger parents have been brought up with expectancies of better services, and are much better informed. It is difficult to know what can be done about apathetic or over-protective parents of mentally handicapped adults who live at home, and one wonders whether parents themselves participate sufficiently in services, or are allowed to do so. Professionals could well ask themselves whether they work with parents enough? Or whether they patronise parents? Consciously-organised joint efforts between parents and professionals are so rare as to merit published accounts when such co-operation takes place. Parents often struggle on alone, trying to help their handicapped offspring, sometimes relying on books which are not particularly relevant. Such ideas as the workshop for parents, or the educational out-patient service which is run in parallel with the medical clinic, or parental involvement with a specialised library resource centre (3), or with a toy library(4), help to turn parents into enthusiastic and well-directed efforts as co-teachers.

5. HOW FAMILIES SEE TODAY'S NEEDS

20. Five mothers, and one sister of a mentally handicapped adult, accepted an invitation to meet us. In addition, a mother who was unable to attend sent a letter which illustrated in a very personal way the difficulties of the transition from school days to adult days, particularly for severely handicapped young people.

21. The mothers were astounded at being asked for their views: for them it was the first time. The following paragraphs reflect the principal ideas put forward. Whilst they seem to concentrate on the ATCs, the general sense of what the parents said applies equally to what might be called the equivalent of ATCs which happen to be within the walls of the mental subnormality hospital. Here are the views they expressed.

22. Parents saw the cessation of education at a chronological age of 16 years and a mental age of 5 years as a nonsensical act. They pointed out that although education authorities have the power to continue education until 19 years, this rarely seems to be exercised. They commented on what was to them a complete cut-off between the junior training centre (now the special school) and the adult training centre. Although education is supposed to be a continuous process, their handicapped youngsters are required to leave the world of education and enter the world of production. The cut-off is more acute because the education department drops out and the social services department takes over. They questioned the sense of this.

23. They saw the ATC as potentially the focal point for handicapped people living in the community, and as the organisational base for many services; but they levelled much criticism at the pre-occupation of most, though they admitted not all, ATCs with work and production schedules. Their feeling was that if the function of the ATC could be correctly identified, many other benefits would flow. They considered that ATCs concentrate too much on occupying the handicapped, and not enough on social and educational enrichment. Their view was that a handicapped person who has lived in a good mental handicap hospital may fare worse, in terms of further education, when he moves into a locality with a traditional work-and-production-centred ATC. They asked why many ATCs have no educational content in the programme and seemed to resist the introduction of teachers; and why many ATCs have no play content in their programme, and seem not to recognise the value and principles of play. Whilst there are good ATCs which do embody education, play and social enrichment as well as work, they said that these are the exception rather than the rule. They even queried the use of the word 'training' in the title 'adult training centre': should it not be simply described as a day centre for mentally handicapped people?

24. There were mixed feelings about sex education for their sons and daughters, but the general mood was progressive and realistic. They were concerned about two levels: the mechanics and the emotions. They thought that sex education for the mentally handicapped should not be administered as a routine, but hoped that thoughtful staff would watch for signs of interest in sexual matters and then give information and advice frankly at that point. We share this view, which is reflected also in Appendix A: useful guidance is also given in the NSMHC's booklet Sexuality and Subnormality. (5)

25. Parents considered that there could be much greater use of TV and local radio in the further education of the mentally handicapped; and in the guidance of parents. They felt that apart from the usefulness of the service it would help to relieve the emotional isolation of parents. We agree: in other countries, for example in the state of Minnesota USA, specially designed radio and television programmes have brought great parent-involvement.

26. Meeting this group of parents was a real learning experience for the working group. The parents impressed us by their fairness and objectivity, as well as by their concern, and they displayed a refreshing sense of humour, even when discussing their own plight. It will be seen that they are not asking for the earth, but rather for a change in emphasis of the service. If it seems that their criticisms are directed mainly at the adult training centre, it has to be remembered that these were parents whose sons and daughters are dependent on what the adult training centre can offer. They find themselves baffled by the fact that responsibility for the education of a boy of 16 lies with the education department whilst when he becomes 17 the whole responsibility shifts to a social service department. The very fact that they saw the ATC as a possible base for the organisation of services for the mentally handicapped, throws into stronger relief their disappointment with the way most ATCs at present function. It has to be said again that parents readily acknowledge that some ATCs are already fine examples of what they hope the other ATCs will one day become.

27. On this question of the ATC, we feel strong sympathy with the views of these parents. Yet we feel that the manager of the ATC, or of its hospital equivalent, is in an almost impossible situation. On the one hand he is sometimes expected to find work which is profitable (but often therefore dull, monotonous and repetitive); and on the other hand he is supposed to stimulate his trainees and help them to develop social skills. This is a genuine dilemma, complicated further by the fact that he is not sure what the endpoint should be for the individual trainee. We are aware of a major review of the work of ATCs which is being undertaken by the Hester Adrian Research Centre, and we hope that the findings will permit a clarification of the role and purpose of the ATC.

28. Thirty years ago, research was already indicating that even severely mentally handicapped people could learn quite sophisticated skills: yet this knowledge has not been put into practice in most cases: and perhaps this is not surprising in view of the marked lack of sheltered workshops which will take in the mentally handicapped. Open employment is also very difficult in times of high unemployment.

29. Elimination of the criterion of profitability might help; but the greatest need is for some sheltered work, preferably on a separate site, towards which the trainee can logically strive. The ATC manager could then begin to formulate a rational policy, and the links between ATC, schools and adult education agencies would become more realistic possibilities.

30. We also support the parents' view about the transfer from special school to ATC at age 16: in many instances this amounts to a rejection of the young handicapped adult by the educational authority just when he is ready to learn, having attained a mental age of 5 years, which is the time at which the normal child starts his education. There should be a complete interdependence between educational provision for children and that for adults: it is a continuum which can be entered at any point.

31. The change from a very structured educational routine to one which is unstructured, for which adequate preparation does not always occur, precipitates problems for the handicapped person and his family. As one mother said: "It's like turning off a light". We are aware that the Head Teacher may permit an extension of school life until age 19 but this rarely seems to occur, usually because there is no room. If this policy is to become a reality, additional school facilities are crucial. We do not support compulsory extension of the school leaving age to 19 years: but we do think that the choice should be there. It is even worse when schooldays end, but no place is available in the ATC, so that the handicapped person and his parents face a long wait.

6. CONTENT AND QUALITY OF ADULT EDUCATION

32. For any person to live his life to the full he needs opportunities to increase his personal and social awareness and opportunities to improve his competence to cope with this increased awareness. Such opportunities will take different forms in different people, but the basic principles of educational planning will be the same whether we are considering mentally handicapped people, the families and staff who specifically care for them, or any other members of the society to which they belong.

33. The problems, possibilities and priorities may be different for mentally handicapped persons than for other members of society, but any of these differences are differences of degree rather than of kind. Our objective must be to enable mentally handicapped adults to develop their potential within the context of a changing society. To this extent, the objectives of an education service for mentally handicapped people are no different from the objectives we may define for any education service.

34. We are obliged to create opportunities for mentally handicapped people to heighten their awareness and confidence, to increase their understanding and use of social skills, to identify their own interests and, once having identified them, to pursue them. By these means, we would hope to enhance the interest of mentally handicapped adults in many aspects of life.

35. As much as possible of the education provision should be based on real-life situations as experienced by the handicapped person. Awareness and confidence can be built up through music, art, drama, movement and dance, games and role play exercises, which might be included in many of these disciplines.

36. The next stage is to transpose increased self-awareness and self-confidence into social skills such as using public transport systems or a telephone; dressing, washing, eating; living as a member of a group and, therefore, giving and receiving. Sometimes there will be a merging of social with occupational skills or leisure behaviour. Being able to cope with a group situation will give an individual the confidence to confront the patterns of behaviour at a factory, office or other place of employment, at a theatre, pub or football ground.

37. However, adult education agencies should not only be aiming to meet the needs of mentally handicapped adults by offering them opportunities and support. An essential part of the education service must be devoted to informing and preparing the public at large about mental handicap. The mentally handicapped

adult will make limited progress if he is continually met by ill-informed, frightened or antagonistic people. If a handicapped man enjoys fishing he will probably derive great benefit from joining a normal fishing club. The members of the club may need information and support: essentially an educational task.

38. The general public must be encouraged to make allowances for the handicapped, and part of the task of educating the handicapped is to help them to develop what they can do well, and learn how to avoid characteristics of behaviour which are not acceptable to the general population. This means devising tailor-made educational opportunities for each individual, building on those areas where he shows maturity and confidence. It will also involve teaching in appropriate adult environments ranging from the organisation of formal classes to the utilisation of everyday experiences and resources.

39. A further word needs to be said about the teachers of mentally handicapped adults. A 'teacher' is a person who creates an environment in which effective learning can occur. So in this context teachers may be any one of a variety of people, including professional educators, other professional staff, and sometimes mentally handicapped persons themselves.

40. Education needs to be such as to enable a handicapped person to take decisions and make judgements and choices in his own life. It must increase the individual's ability to improve the quality of his own life, however minimally. The personal choice and freedom implicit in this context must obviously be exercised within a socially acceptable framework which may have to be more limited for some mentally handicapped people than for others. But the directions and guidance given must not lead to increased dependence of the learner on his teacher.

41. Individual needs and abilities must be taken into account. In an onrush of enthusiasm for social development it would be easy to dismiss the case for teaching basic skills like reading, writing and counting, which may be in some cases a real goal and indeed a status symbol. Furthermore, it is often at the age of about 16 years to 20, that handicapped people become ready to learn reading and writing. Some practical suggestions on educational opportunities are given in Appendix A.

7. WHO IS TO UNDERTAKE THE FURTHER EDUCATION OF THE MENTALLY HANDICAPPED

42. Everybody in life is a teacher. Whether we intend to or not, our own actions and reactions influence those around us. Certainly everyone who comes into contact with the mentally handicapped person is a teacher. Perhaps those 'contacts' not professionally qualified as teachers, but whose primary skill lies in some other direction, including parents and volunteers, might well be called co-teachers. Teaching leadership ought to come from professionally qualified teachers with the special skills of education: how to approach the task of overcoming learning difficulties; how to listen. The job of translating this teaching into everyday life will often fall to the co-teacher, including the parent or volunteer.

43. Adult education should not be regarded as an optional extra, but as a basic necessity, an integral part of the development of the individual. Wherever services are being provided for mentally handicapped people, adult education should be at the very heart of the central operational policy. It will not take hold if it is regarded as a frill. Various exercises have shown how mentally handicapped people can choose: but they can't choose if they are not given a choice; and they can't exercise a choice unless they are helped in the sheer technique of decision-making.

44. It is not only staff who can motivate the mentally handicapped. Families and friends can be prime movers. They need to have the know-how and the determination to push for appropriate adult education. They themselves must teach, and look for teaching opportunities all the time at home, or whenever they visit their relatives in hospital. They themselves can be a pressure group for better facilities, and they could become a major motivating force. Parents need to learn to use situations: a determination to maintain conversational levels with a young handicapped person may well be more effective than a determination to secure the services of a rare speech therapist.

45. Some 'contacts' clearly seize the role of co-teacher enthusiastically, but others do not, perhaps because they are more interested in the traditional work of their own profession or trade. Yet it seems to us that for the mentally handicapped, the group approach between professionals is of cardinal importance. The term group approach is not just an 'in' phrase in an anti-authoritarian era: it is fundamental. Care staff should be drawn into class work, and teaching staff should be drawn into care work. What is taught in the school has to be continued in the living situation: what is taught in the living unit has to be continued in the school. In educational aspects teachers take the lead; in caring aspects, others take the lead: between them is a considerable overlap for which a uniform policy is utterly essential. The group who need help are not just the mentally handicapped: it includes the carers,

the teachers and the parents. If the staff and the handicapped see themselves as one group, the wastefulness of borderline disputes between professionals, and of social distance between staff and the handicapped, will largely disappear.

46. We considered whether there was a case in Britain for following the lead of some other countries and establishing a separate professional group which bridges the work of the care staff and the qualified teacher. We think not. There are enough disciplines in the field already. The task which in some countries would fall to the so-called pedagogue is the task in this country which falls to the group or team we have been describing. Teacher, nurse, parent, psychologist - all have a teaching component in their work but they exercise it collectively. If they are to do this, we think they will need a co-ordinator: a middle man: someone who knows the possibilities of adult education for the mentally handicapped and who can widen the outlook of both providers and recipients. We return to this topic in paragraph 63.

47. We have given some thought to the way in which people might actually operate as co-teachers. For example, deportment is a good subject to teach. It might involve a teacher from a charm school, or a physiotherapist, or the music and movement group; or it might equally be taught just by allowing nurses and care staff to dress in attractive normal clothing, thus providing an everyday and persuasive model. Group discussion could centre on why advertisement models, or pin-ups seem to look so good. This kind of motivation is valuable, but it is not enough on its own: it has to be refined and sequentialised. For example, knowing the body could involve some straight anatomical or physiological teaching. It could involve some modelling, as in deportment; or it could involve drawing out the lessons when the mentally handicapped person is dancing to rhythmic music. These are just some of the instances in which specialist skills can be diluted and diffused to the mentally handicapped through non-specialist workers. As a further example, a head porter established a first-class teaching relationship with two mentally handicapped men when they were attached to him for general fatigues: he had the gift of teaching and of encouragement: he became in effect a co-teacher. Staff themselves must learn to change their role so that they become co-teachers and partners of the mentally handicapped.

48. It is not too much to claim that if we wish to achieve a good further education system, we shall need first to alter the social and managerial structure of the residential setting. It is noticeable to many of us how the demeanour of residents and of staff changes when they are outside the hospital. A hospital party on a residential holiday seem to achieve a different set of relationships. The handicapped become more independent and more individualistic, readier to learn by experience, whilst the staff, out of the institutional situation, seem less concerned with preserving routine, or keeping social distance, and readier to teach by example.

49. Increasing the number of teachers available will not automatically solve the problem. Radical change in the living situation is equally, or even more, important. At present, bad environment and poor staff ratios often combine to untrain and desensitise the mentally handicapped. To staff in that kind of situation, any talk of further education can be just a hollow joke. Education can only be prescriptive within the range of available resources, educational or residential, and these are known to be inadequate. There are enormous practical constraints. For example, if one nurse is looking after forty severely subnormal people, how can the nurse be a co-teacher in that situation? He is bound to be forced back into routine, block treatment and depersonalisation, and be compelled to maintain social distance between himself and the mentally handicapped person.

50. But given reasonable staffing, a programme of adult education such as is described in Appendix A, can do much to combat these stigmata of a bad service. The ideas in that programme come directly from the experience of members of the working group.

51. What about the teachers themselves? What about the college of further education? We do not see adult education just as a service that supplies something: we see it essential that residential care staff of all kinds are hooked into the system of education together with the residents; just as adult education teachers need to be hooked into the residential or family setting. Whilst an administrative and financial link between the hospital and the college of further education, at the top, is essential, even more important is the link between teachers and residential staff, because through that link, skills of further education can be injected into the daily living situation.

52. How can all these workers learn about one another's approaches? It is likely that hospital staff and further education staff would benefit by some co-training: among other things it would help to avoid the conflict of value systems between the two worlds - hospital and college - which some mentally handicapped persons will find themselves inhabiting. At Calderstones Hospital, in Lancashire, the LEA provides modules of training for nurses, covering the basic principles of education and assessment. The next step would be for the hospital to provide modules of training for teachers, covering the facts of mental subnormality. Effecting a link between hospital and college may well call for change in a number of established systems. This proposed involvement of the residential care staff with the college may be inhibited by the managerial system in some, though not all, hospitals: staff may need to work a flexible pattern of hours, or to go in and out of the hospital at odd times. The nursing management system must become flexible enough to meet this need.

53. We do not think that cost should be a bar. A hospital authority may pay further education course fees: or local authorities might help by waiving or reducing fees. Sometimes there is a cost-sharing partnership between hospital and

LEA. In addition, we wonder whether there could be any objection to residents paying their own way, for courses of their own choice, if they wish: would not this be a further recognition of their essential adulthood? A further possible stumbling block would be the question of personal records. The college will need a record of the background of the mentally handicapped person, though it need not contain intimate or family details. The college needs a short biography, and a note of such things as liability to fits, or a need for a diabetic diet. There is no reason why rules of medical confidentiality should inhibit the passage of this essential information, provided it does not lead to a fall in tolerance by the education authority.

54. We would see it as essential that there be a link between the special school and the adult education agency. A gap there can be as disastrous as one between the special school and the hospital. And the ATC needs to link its programme to the school on the one side, and the adult education agency on the other.

55. Sometimes further education seems to be given only to the more able. The needs of all mentally handicapped people will only be met when:

(a) persons of all dependency levels are included - not just a selected few with minimal disability;

(b) teachers and co-teachers respect one another's training and discipline and are prepared to work asocial hours and in conditions sometimes far from ideal;

(c) those responsible for the setting up of an education service for mentally handicapped adults understand that at least 90% of such education and training will, for a long time to come, be required to be given within existing centres of care - i.e. adult training centres, hospitals, etc.;

(d) the training of teachers and co-teachers is radically re-orientated towards the total understanding of the mentally handicapped person. Only then will 'professional attitudes' which at present hinder educational programmes be finally overcome.

56. We must point out that only a proportion of mentally handicapped adults will be suited to attend at the further education centre: many more will experience adult education in the adult training centre, in hospitals, or even at home. Just as there exists this limit for the mentally handicapped person, there may well be a limit for the educationist in the service he is expected to give. Whilst it is right for him to be involved in toilet training as part of an overall programme, if habit and sense training is the limit of development, this may be considered to be extending the educationist's brief too far. (6)

8. ORGANISATION

57. Recent work shows that the majority of education authorities have an incomplete idea of the needs of mentally handicapped adults: they need to be shown success if they are to believe what can be done.

58. There is not so much a lack of will or commitment as a double ignorance: not all local education authorities fully understand the needs of the mentally handicapped. Not all doctors, nurses, social workers and parents understand what the LEA can provide, or how to go about getting it.

59. We stress the importance of including the educationist at three levels: in the case conference; in the team managing the mental handicap hospital; and in the health care planning team which is planning mental handicap services for the area. The inclusion of the educationist is not merely desirable: it is essential. We cannot see that services at any of these levels will be complete without his presence.

60. Furthermore, just as there is need to reflect informed mental handicap opinion of a modern kind among the staff and members of community health councils and joint consultative committees, we would include in this the need to have an educational presence at all times. For example, it is not possible for a community health council to decide whether or not the community is getting a good mental handicap service unless it knows whether the handicapped are getting a good education service. It is no answer to say that this is not an NHS service: we cannot help the way in which the service has been split up by legislation, but we can try to ensure that we work in a unified way, even if there are three different paymasters.

61. Parents must be motivated to press for the further education service for their handicapped relatives, as the ordinary right of an ordinary citizen, not as a topic for special pleading. The presence of an educational representative on the health care planning team, which we have already recommended, and on the case conference, will assist motivation.

62. Educational agencies should not be seen as offering only a shopping list of available courses: instead, it ought to be prepared to move in to ascertain demand and then to meet it, recognising that this may sometimes happen in unorthodox ways.

63. The process would be helped by the appointment of an educational adviser who sees the problem and who not only offers advice to the rest of the team, but has some control over local education resources. In the course of our enquiries we have come across several instances of people operating in this role, the need for which was also mentioned at paragraph 46. For example, we are impressed by the evolutionary and collaborative approach shown by the Wiltshire authorities, and by the attempt at an intra-hospital adult education system as developed at Calderstones, Lancashire. The Wiltshire scheme is described in detail in Appendix B.

9. COMMUNITY INVOLVEMENT

There are three processes with which all staff should be concerned.

64. Firstly, information-giving. Even today it is reasonable to assume that the majority of the general public have little real knowledge about the nature, extent or implications of mental handicap. The public is equally ignorant about the potential capabilities of handicapped persons. However, it is by no means certain that medical and educational staff are capable of mounting an adequate information-giving service. While some GPs are well informed about the causation of mental handicap, they have little knowledge about the educational and community services and facilities that are available. Equally limited are the educationists who may have experience and competence in teaching the handicapped but little knowledge of the medical or social aspects of handicap.

65. Thus, it is essential to ensure that all professional workers give themselves ample opportunity to inform each other in order that they may be better able to inform the handicapped and their relatives and the general public.

66. The second distinct process is educating. This implies consolidating, re-inforcing and developing the newly gained information at the disposal of people. All staff working in health care must assume the role of educators. This is not to say that professional disciplines must be eroded to the point when all become educationists, but rather to suggest that the roles adopted by personnel are significant indicators of their potential success. It is the community education process which must develop tolerance, understanding and responsibility amongst the general public. These characteristics are born of information and empathy. To some extent, empathy is a natural virtue of the young but it is necessary to rationalise and justify fellow-feeling within the education system. Concern for one's family and property may give rise to an increasing selfishness and intolerance as one becomes older.

67. The third process is involving the community. If the objective is to create a more open and understanding society, workers with the handicapped must seek ways of involving all sections of the community, handicapped and non-handicapped, in widening opportunities for the handicapped to give rather than to take. There are, at any point in time, cultural and social limits to the acceptance of the handicapped as members of the community. These limits must continually be eased back. The nature of voluntary organisations working with the handicapped has changed in accordance with increased knowledge and competence of voluntary workers and the relationship between voluntary, often untrained, workers and professional workers. However, work with and by established voluntary organisations often implies involving only the converted and not reaching out amongst those people who have little working knowledge or experience of mental handicap.

68. In all three processes, full advantage must be taken of modern aids to education. Films, television, radio, tapes, are all of great value. Nevertheless, it must be said that the most important way of extending the work of educating the community is by featuring the nature of handicap and the needs and potential of the handicapped as integral parts of any curriculum concerned with people and society. Only by informing, educating and involving the young, middle-aged and elderly through all sectors of the education system will society as a whole and, in particular, the handicapped, benefit.

69. The Open University now offers a one-year course on "The Handicapped Person in the Community" which includes a radio and television component, but in general not nearly enough opportunity is taken to use these media in the attempt to bring about more enlightened public attitudes.

70. A notable attempt to bring a better understanding of all handicaps has taken place in Sweden, where the illustrated textbook Alla Vi [7] is extensively used in schools, an example which could well be followed in this country. In Britain, a great deal of helpful contact between young people and the mentally handicapped is already taking place through the social studies component of the school syllabus.

71. In the USA, the National Association for Retarded Citizens offers short courses, or modules of training, to Police Colleges and other public services, and also to members of key professions, for example law, accountancy and religion.

72. The recent NHS reorganisation makes it possible for Health Education Officers to organise constructive and educational publicity, linking the efforts of statutory and voluntary agencies: a good example of this has recently taken place at Newcastle-upon-Tyne, where a week-long exhibition on Play and Toys for the Handicapped has been organised, with public workshop-sessions.

10. SUMMARY

1. Adult education for mentally handicapped people is not an optional extra, but a basic necessity.

2. Adult education requires corporate commitment by all agencies: education, nursing, medical, day care, social service and community.

3. Adult education should apply to all ages from the date of leaving school onwards: it should go on throughout life.

4. Wherever mentally handicapped people live, or work, or occupy their time in groups, there should be opportunity for access to a programme of adult education.

5. The accent should be as much on social as on academic education. Such topics as decision-making, relationships, awareness, play, communication and confidence come before the acquisition of more formal educational skills.

6. Adult education of the mentally handicapped should also provide for additional handicaps such as blindness and deafness, for which there already exist some valuable community-based services.

7. A co-ordinator of adult education is needed between the three services: hospital, social service and education. A good example of such an appointment is given at Appendix B.

8. Adult education staff should be involved in assessment and programming. The aim should be to assess each handicapped person individually, and to connect him with the full range of available educational facilities.

9. Adult education teachers will need induction into matters relating to mental handicap.

10. The community itself needs enlightenment in the facts of mental handicap.

11. All people who come into contact with the mentally handicapped must be aware that they are in fact co-teachers: they may need help in order to perceive this. People whose normal work is outside the world of mental handicap, e.g. police, lawyers, accountants, need to learn something of the true capacities of mentally handicapped people.

12. Contacts of all kinds should be in partnership with teachers. The emphasis is on the word partnership. There are many people who are not qualified teachers but who are 'naturals' within the range of their own hobby or special interest.

13. Whilst there is need for a link between adult education departments and the Special Schools (both 'M' and 'S'), it is necessary to be careful to ensure that in some situations schoolroom-based methods do not spill over into further education.

14. There should be much stronger links between the ATC and the school, and schools and ATCs together should develop school-leaver programmes, to prepare for the shift to adult education. Adult education should occupy at least half the working week of the ATC.

15. The adult education needs of the mentally handicapped person living in the community are not easily ascertained and may be overlooked. This is made more difficult by the fact that there is no single service and no central information. All handicapped people, wherever they may live, need regular assessment of needs, and this should include adult education needs.

16. In establishing adult education, not only the parents should be consulted, but also mentally handicapped people. There should be better parent-representation on school and ATC committees. If we are to attempt to take into account the views of the mentally handicapped, then we have to learn to listen, and to listen patiently.

17. The theoretical possibility of staying on at school until the age of 19 years rarely becomes a reality owing to shortage of room: handicapped people and their parents need to have more knowledge of their rights in this matter, and of the availability of existing adult education resources.

18. Help may be needed with adult education fees; and grants are needed in order to get the handicapped person out of home and onto educational visits.

19. Peripatetic teaching for adults who cannot come to adult education agencies is vital. This applies equally to very handicapped people living at home and to the multiply-handicapped and behaviour-disordered living in the hospital.

20. Continuity is essential and the adult education facility should not be closed for long periods: a summer break of two or three weeks is not unreasonable.

APPENDIX A

EDUCATIONAL OPPORTUNITIES - SOME PRACTICAL SUGGESTIONS

(This is not an exhaustive list)

Adult education should help

to communicate

to make relationships

to cope

to exercise choice and make decisions

to have fun and enjoyment

to develop curiosity

to produce a challenge

Self-discovery

Adventure camps

Exploration areas

Play and playgrounds

Sand and water

Wendy house

Growing

Deportment

Dressing

Mirrors and photographs

Knowing one's body

Sex education

Art

Music

Drama and role play

Opportunity to give service to others

Awareness and involvement

Use real-life difficulties as basis for role-play

Belonging in society

How and where to get information

How to ask: which official do I ask?

How to explain one's own difficulties to another

Norms of dress and behaviour

Hygiene

How to be part of a group

Home-making

Public transport

Money

Public notices

Smoking: when you can and when you can't

Drinking: e.g. comparative effects of vodka and shandy

How to choose

Recognition of passage of time

All life is education

Handicapped people need to learn how to go about the activity they are interested in, whether it's work or play.

For example - a theatre visit

What's on?	Programmes
Booking tickets	Scenery
Finding your seat	Back stage
Where and how pricey the bar is	The interval bell
Where the loos are	Standing up to let people get past you

Similarly for getting a job, going fishing, the Big Match, the Bingo Hall, and so on.

Developing relationships with other people

In concrete terms, people won't develop relationships with those who are unpleasant, or whose demeanour and habits seem outlandish. We can help others to understand, for example, that the grimaces and mangled speech of a person with cerebral palsy conceal a very ordinary and acceptable person; or that the man with no speech at all may have a great deal to communicate by gesture or expression. We can in fact help the public to make allowances, and to understand.

But the handicapped, too, need educating in how to be less obviously different: to relate easily with other people they need to have learned to be continent, able to feed themselves decently, and able to dress themselves.

Continued development: experience: interaction

There is no limit to the possibilities of continuation.

Education makes you want to go on being educated.

Topics include:
- the disciplines imposed by society
- self-discipline
- religion and ethics
- socio-political matters
- issues of the day
- sex and marriage

'Outside' speakers not so necessary: what is needed is guided discussion within the group.

The community needs to learn the truth about mental handicap

A visit to the back-wards of the local 2,000-bedder may merely confirm the visitor's opinion that the mentally handicapped should live as a race apart. Mentally handicapped people should be seen in non-dependent roles - digging gardens, building, doing voluntary work, doing factory work, home decorating, and so on.

The challenge of the profoundly handicapped

There are some residents who are unacceptable to the general programme of activities in the hospital and who present severe behaviour problems. They need to be included in a programme, but this presents immense difficulty: not nearly enough is known about meeting the needs of such profoundly mentally handicapped people. Behaviour modification is said to be showing some results, and the Institute of Mental Subnormality organises courses in this approach for hospital staff and for parents. A five-week experimental course in creative activities for the severely handicapped has been sponsored by the King's Fund at Redland College, Bristol. Experimental programmes have been worked out at St. Lawrence's Hospital, Caterham, and Calderstones Hospital, Blackburn, amongst others.

APPENDIX B

THE EDUCATION OF ADULTS WITH MENTAL HANDICAP

This paper describes developments in the Wiltshire Hospitals which, since the NHS reorganisation, are now part of the Wiltshire Area Health Authority, Swindon District. It is a shortened version of a report originally prepared in July 1974. A summary is given of events over a period of seven years, so as to permit an examination of the characteristics of a fruitful relationship between a health authority and a local education authority.

Developments 1966 - 1974

In 1966 the Wiltshire LEA appointed an adult education tutor for three sessions a week in Pewsey Hospital. At the outset, the tutor was concerned solely with teaching mentally handicapped patients in the hospital. In 1968 the appointment became full-time, with the tutor being employed by the local education authority, but with half his salary being refunded by the then hospital management committee.

At this stage the organisational and advisory roles of the tutor began to develop, and proceeded rapidly after the appointment in 1971 of a full-time adult education tutor in each of the two major hospitals in Wiltshire (Pewsey and Burderop). The original tutor became adviser/tutor, and began to visit the other hospitals in the group, including the two hospitals in Oxfordshire.

In 1974, following a great deal of multi-disciplinary and inter-service discussion, agreement was reached on the following:

(a) An increased contribution by the education authority

(b) The importance of an educational contribution to the training of the severely handicapped

(c) For the less severely handicapped, a division of the working day into approximately 60% for industrial and work training and 40% for educational activities, a term which was broadly interpreted and not confined solely to the work of qualified teachers.

As a result of these decisions there has been a great increase in the education authority provision during the years 1972-74. After pilot schemes, to which both the hospital and education authorities contributed, there are now funds available for approximately 1500 hours per year of part-time teaching of adults in the three hospitals in Wiltshire with a total adult population of approximately 450. This is in addition to the work of the full-time tutors. The teachers provided by the LEA are under the control of the educational adviser/tutor but they work as members of the education and training teams which are headed in each hospital by a nursing officer.

Current Position of the Adviser/Tutor

Since the developments seem to have depended on the role of the educational adviser/tutor, there is advantage in analysing his duties as they are at present.

Advisory duties

(a) He acts as adviser both to the district health authority and the local education authority. He thus provides a link between the two authorities.

(b) He is a member of the psychiatric division sub-committee and can express his opinions on education and training for the mentally handicapped.

(c) He is adviser in each hospital and can thus promote the educational needs of the mentally handicapped both generally and individually in inter-disciplinary meetings, case conferences, etc..

(d) He is adviser to the nursing officers in charge of education and training and can therefore make a contribution to organisation and discuss teaching method with the teachers he employs through the LEA and the staff appointed by the health authority.

(e) He is a member of the District Health Care Planning Team for Mental Handicap.

Organisational duties

(a) He provides through the local further education area of the education authority the part-time teachers required.

(b) He organises, in consultation with the nursing officers, the programmes of the teachers both full and part time.

(c) He encourages and channels provision from other sources: for instance the Workers Educational Association has recently shown interest in the education of the handicapped.

Tutorial duties

(a) He assists in in-service training.

(b) He acts as tutor on the educational sections of the syllabi for student nurses.

(c) He supervises and holds tutorials for student nurses attached to the education departments.

Other duties

(a) He provides a link between the hospital staff and the staff of the children's school sited in the hospital. This is of particular consequence in discussions on the future of school leavers.

(b) Up to April 1974 he co-operated with the Training Officer of the then Oxford RHB in the courses organised by that officer. Some of these courses, which were attended among others by officers and teachers of various education authorities, were an important contribution to the understanding of the educational needs of the mentally handicapped.

Analysis

Whether an educational adviser is essential to the development of a good educational system for the mentally handicapped adults, is open to discussion. There may be other methods by which inter-departmental co-operation can be achieved. What is clear is that education is not an island inhabited by professional teachers to which students who are mentally handicapped are ferried for brief sessions. When this is accepted, education becomes part of the general service to those who are mentally handicapped and dividing lines become blurred. Indeed, the dinstinction between education and training ceases to exist.

If this is accepted, then it would seem to follow that the effective integration of education in the body of training depends on the activity of an individual conversant with the systems of provision in adult education, with knowledge of the educational needs of the mentally handicapped, and with experience of the complexities of the places in which they live (hospitals) and the places they attend for training (training centres).

(a) He must function as an educationalist within the institutions in which he works. Thus if he works in hospitals, he must be located in one of them and the number must not be so large that he becomes only an occasional visitor. Activity at the operational level - discussing programmes and teaching method, acting as tutor in staff training and attending hospital meetings - are essential both in helping him to keep in touch with reality and in demonstrating his involvement.

(b) He must have free access to the officers of the authorities with which he works; thus if he works in hospitals, he must have secure links with both the area or district health authority and the local education authority. The effectiveness of his contribution depends on his opportunities for influencing each body and on the ease with which he can act as a go-between, not totally committed to any one authority, but totally committed to the needs of the mentally handicapped. This freedom comes most easily when there is a joint appointment.

(c) He must be prepared to contribute to and if necessary initiate inter-disciplinary discussion on education and training within each hospital. The communication of any proposals to the LEA will rest solely with him and he can contribute to the presentation of the case to the health authority.

(d) When the role of go-between is inadequate, he should propose a joint meeting between officers of the two authorities.

This paper has been concerned solely with the links between some relatively small hospitals and educational authorities. It says nothing about people with mental handicap who are the responsibility of the social services in their work in adult training centres, or of those who are neither in hospitals nor attending training centres.

Although there are links between staffs in hospitals and in the training centres, and although there is developing an educational contribution to the work with those attending training centres, it is clear that much remains to be done. If there is to be a completeness about our efforts for the mentally handicapped, there needs to be a much closer co-operation between the health authorities, the social services and the education authorities in matters of education and training.

Finally, there are those, usually mildly mentally retarded, included in the Russell Report under the general heading of disadvantaged, often illiterate and socially incompetent. They do not belong to 'captive groups', as do those in hospitals and training centres, and, as has been discovered both by education authorities and other organisations such as the WEA, the problems of finding them and motivating them to take an interest in continued education are very difficult to solve.

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REFERENCES

1. GREAT BRITAIN. DEPARTMENT OF EDUCATION AND SCIENCE. Adult education: a plan for development. (Chairman, Sir Lionel Russell.) London, H.M. Stationery Office, 1973. pp. xxii 311.

2. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and WELSH OFFICE. Better services for the mentally handicapped. London, H.M. Stationery Office, 1971. pp. iv 67. Cmnd. 4683.

3. KING EDWARD'S HOSPITAL FUND FOR LONDON. KING'S FUND CENTRE. A library service for the mentally handicapped. London, King's Fund Centre, 1973. pp.32. (Mental handicap paper no. 3.)

4. TOY LIBRARIES ASSOCIATION, Sunley House, 10 Gunthorpe Street, London E1 7RW. Secretary: Mrs. Leslie Moreland

5. KATZ, G. editor. Sexuality and subnormality: a swedish view. London, National Society for Mentally Handicapped Children, 1972. pp. viii 20. (Subnormality in the seventies no.4).

6. GREAT BRITAIN. DEPARTMENT OF EDUCATION AND SCIENCE AND DEPARTMENT OF HEALTH AND SOCIAL SECURITY. The education of mentally handicapped children and young people in hospital. London, DES and DHSS, 1974. pp.12. (Circular 5/74 (Department of Education and Science) Circular HSC(IS)37 (DHSS).)

7. FLINK, M. and others. Alla vi. by Marianne Flink, Bodil Göransson and Ingela Olsson. Stockholm, Almqvist and Wiksell, 1970. pp.82.

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