

SERVICES FOR THE MENTALLY DEFICIENT

A Description of Services in British
Columbia in the Light of British and American
Experiences.

by

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ABSTRACT

This study outlines some historical backgrounds and present-day concepts regarding the mentally deficient, followed by a review of progress and experiences in Great Britain and the United States, in preparation for a description and discussion of services being offered mentally deficient persons in British Columbia. This subject is of particular concern to the field of social welfare since the mentally deficient represent a large group of persons who, along with their families are dependent upon the Social Services. The Social Worker's responsibilities for the mentally deficient begin with the period of initial diagnosis and planning, continue through training, and are particularly evident through rehabilitation and the supervision in the community.

In preparing the material the literature was reviewed and classified so that some similarities, differences, and gaps in the programs of Great Britain and the United States would be readily apparent, and could be applied comparatively to a similar description of services to the mentally deficient in British Columbia. The latter was obtained from available literature and reports, and especially from a series of interviews with persons from representative agencies who were concerned in some way with giving services to this group.

The study presents, in outline, the advanced state of services to the mentally deficient in Great Britain and some parts of the United States. The description of British Columbia services shows many gaps, and the need for a comprehensive program which, if implemented, would enable the mentally deficient person to function at his maximum level, throughout his life. It is found that the Parents' Associations are becoming a strong force in the advancement of services to the mentally deficient, especially in the area of education and training. The increased interest on the part of the public can be expected to have a quickening effect on the formation of a new program, and those who are working in this area must be prepared to give leadership. The study presents a foundation of basic information about the mentally deficient in British Columbia upon which it is hoped, more specific research studies can be made toward providing better service to the mentally deficient.

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CHAPTER I

THE NATURE AND EXTENT OF MENTAL DEFICIENCY

If a large Canadian city of 150,000 inhabitants happened to be populated entirely by citizens who were mentally deficient, then their more fortunate countrymen would be acutely aware of the magnitude and formidable problems of such a handicapped group. Instead, however, the mentally deficient are distributed throughout the population as a whole where neither their numbers nor their needs have been generally appreciated and where, as we shall see, they have often been thrust out of sight and mind by society. Then again, it has been a difficult group to describe with the result that the public has never had the use of a word which stood for a neat and clear description of the mentally handicapped, as contrasted to easily identifiable diseases such as Diphtheria, Scarlet Fever or Poliomyelitis. Mental Deficiency differs from these because it is a broad term which includes a varied group of persons whose only common denominator is that they have been intellectually affected.

In order to discuss the incidence of mental deficiency a preliminary definition is needed. Perhaps this could best be introduced with a comparison of physical differences in humans. In a large group of persons the majority would appear to be neither tall, nor short, and would be called average or normal. A few would be seen to be unmistakably tall and some would draw attention for their shortness. Persons who showed extremes in this matter of height would receive special names such as giant or dwarf. So it is also with intellectual stature where the giants are known as men of genius and the dwarfs as idiots with, in between, the large group of normals,

2.

tapering off gradually to each extreme. This continuous transition from the normal to the defective does not provide a natural boundary between these two groups so that in order to arrive at a definition other methods must be explored. A representative sample of the population might be taken and arranged according to the individuals' mental endowments, in decreasing order of intelligence. A dividing line might then be arbitrarily made and a definition based on this decision. However, at any point of demarcation based solely on intelligence, which might be set, it has been found that there are many persons of lesser intelligence who are functioning well on their own, who would be labelled defective, much to their detriment. Similarly, persons of greater intelligence, who would thus be declared normal have been found to require care and supervision. There is no single point on this scale of intelligence where injustices would not be done, either by wrongfully including those who are already supporting themselves or by denying care to some who require care due to mental deficiency.

The main and final test has thus become the social criterion. The practical test is whether or not the individual is able to make a satisfactory and independent adaptation to the ordinary environment constituted by his fellow men. We can now tentatively define a mentally deficient person as one who, as a result of defect of mental competency, is unable to make an adequate and independent social adjustment.

In Britain and the United States many careful surveys have been carried out since the turn of the century to ascertain the number of mentally deficient persons in the population. Enumeration has been very difficult on account of such factors as family feeling about having a defective member, the milder

degrees going unrecognised as mental deficiency, and the general lack of planning and facilities for this group. However, after many varying reports, there is now substantial agreement on both sides of the Atlantic, so that the British authority A. F. Tredgold supports the American findings as corresponding with his results and writes as follows: "Dr. Edgar A. Doll says that generally speaking it may be concluded that one per cent of the total population is mentally deficient in the social sense, and that this figure has been confirmed by both intensive and extensive local surveys."¹ Furthermore, they both agree that more than two per cent. of the compulsory school-age population are mentally deficient. The eminent British authority on mental deficiency and the schools, Cyril Burt, has found this figure of two per cent. to hold true in the English school-age group ² while other surveys in Scotland and in America have shown a school-age incidence ranging between about two and three percent.³ The much larger percentage found in school-age children is believed to be due to two factors. Firstly, the life-span of the more severely affected children is shorter and thus many do not survive into the adult age groups. Secondly, the mildly affected young adult, having left the more definite scholastic standards of the schools, may become self-sufficient in the outside world and can no longer be regarded mentally deficient as defined.

The finding that ten in every thousand of our population are mentally deficient and, even more startling, the fact the incidence rises to over twenty out of every thousand children of school age, cannot help but bring home to each of us the need to know more about so widespread an affliction.

1. Tredgold, A. F., A Textbook of Mental Deficiency; Bailliere; London; 1952; p. 18.

2. Burt, Cyril, The Backward Child; University of London Press; 1937; p. 81.

3. Penrose, L. S., The Biology of Mental Defect; Grune and Stratton; New York; 1949; p. 21.

The White House Conference on Child Health and Protection, in summarizing the significant findings on the handicapped child, presented a list of nine broad groups of handicapped children with a numerical estimate for each. After taking into account differences in definition, the list still showed that mental deficiency is by far the largest single handicapped group in the United States.¹ More recently, Ernest N. Roselle stated that the Connecticut Study had compared mental deficiency with other handicapped groups and had found that there were about as many mentally deficient children as there were of all other handicapped children put together.²

Within this very large group are persons of widely differing degrees of intellectual capacity and with varying ability to apply this to the problems of living. As an aid to understanding and working with the mentally deficient, the group has been traditionally divided into three parts in order of decreasing intellectual competency. They are now known as Mild, Moderate, and Severe Mental Deficiency.³ This parallels the older but perhaps better known classification of Moron, Imbecile, and Idiot. These three terms, which have been somewhat corrupted by popular usage, do not point up the concept of gradual transition or distribution from one grade down through the next.

One further class of persons, which will be referred to from time to time, embraces those whose mental competency places them above the mentally deficient but below the average or normal group. This in-between class as thus defined we will call the Borderline Group. The borderline group does

1. - - - "The Handicapped Child"; White House Conference on Child Health and Protection; The Century Co., New York, 1933.

2. Roselle, E. N.; "New Horizons for the Mentally Retarded"; American Journal of Mental Deficiency; Vol. 59 #3, Jan. 1955, p. 364.

3. Sloan, W., Chairman; "Progress Report of Special Committee on Nomenclature, A.A.M.D."; American Journal of Mental Deficiency; Vol. 59 #2, Oct. 1954, pp. 348-351.

not contain persons who are mentally deficient and is actually made up of a very large number of subnormals, who may require, in their younger years, special help and attention in the public school system. Otherwise, they are not particularly noticeable and in adult life they make up the bulk of the unskilled labourers where as such, they are an important and integral part of society. This group is mentioned here because there can be considerable interchange between persons in the top levels of the mildly deficient and those in the lower strata of the borderline. This will take place when, for example, the individuals' ability is increased through training to the point where he can cope successfully with the demands of social life. Conversely, his decline with age, or perhaps his inferior position during times of general unemployment, may cause him to be reclassified as a mentally deficient person.

The Mildly Deficient make up the largest class, accounting for about three quarters of the mentally deficient.¹ They are not only slow starters in the race of life but can be expected to have a difficult time in their progress towards already definitely limited goals. If the child receives an extra share of encouragement, affection and security he may progress through the usual childhood achievements, but will take about twice as long to do this and only after much patience and repetition on the part of the parent. When others are ready for school this child still requires special help towards working and playing with others and must receive a fairly lengthy pre-school training. He then requires special schooling where he will receive much individual attention and where the teaching methods are expertly

1. Penrose, L. S.; The Biology of Mental Defect; Grune and Stratton; New York; 1949, p. 20.

designed to hold his interest in spite of his short span of attention and his slow rate of learning. Most of his class will learn to read and write but few will reach more than the fourth or fifth grade of school. Those in the mildly deficient group can, however, very often be trained to develop social competence and adequacy in employment. They may become steady, pleasant, and willing workers to whom routine repetitive jobs are a challenge. They carry out important tasks which normal persons find too monotonous, (for example, dishwashing), in many work areas particularly the food, laundry, and auto trades, buildings and janitor work, hospital and personal services, farm and household work. In return they must be offered some protection, due to their definite limitations, which can well be given in a small shop by understanding co-workers.

The moderately deficient class will not be expected to achieve much academically beyond such practical things as reading signs for their own protection, elementary counting, and simple operations which would help them to find their way about the community. Their educational program is usually one of training in self-care, socialization, and limited economic usefulness. Thus they can be taught to help around the house with cleaning, washing dishes, etc., and outside can do supervised jobs in the garden. Members of this class are limited in their social competency and require some supervision of their affairs and many require maximum environmental supervision.

The severely deficient person at best can only learn to care for his personal self. There will be little interaction with other individuals and constant supervision in a restricted environment is required. They are completely dependent upon others for the necessities of life and cannot survive without care. Even this most severely deficient group are able to respond to kindly

and imaginative care by improving their personal play habits and being able for example, to enjoy seasonal parties and picnics on the lawn.

Mental deficiency, besides being a large-scale community problem, can also bring about particularly trying experiences to the parents and family of a child so afflicted. / Mrs. Norma L. Bostock of the National Association for Retarded Children writes of this both from personal experience and from that of her many fellow parents.¹ She endeavours to share with her readers, who are professional persons, the strong personal feelings and conflicts which have in the past been aroused within the parents and family by the birth of a mentally deficient child. Mrs. Bostock describes the typical situation with her group, in which the parents had indulged themselves with the usual dreams of expectant parenthood only to see the dream turn into a nightmare; a mentally deficient child had been born. A nightmare because the parents had been raised in a generation when every tradition and custom clearly placed a stigma on the parents of mentally deficient children. Because of their upbringing the parents, and the grandparents too, felt guilty and often angry about this happening, which attitudes placed a strain on family and marital relationships and gave rise to many personal doubts and fears. They knew little or nothing that was constructive about what might be done for such a child but could only see complete destruction of hopes and plans for this and any further children. / Many parents became very sensitive about this event and either tried to deny the existence of such a child or withdrew in shame from their normal community, and personal social activities. Under such circumstances the parents were quite unable to look at the child objectively and

1. Bostock, Norma L.; "How can Parents and Professions Co-ordinate, etc."; American Journal of Mental Deficiency; Vol. 60 #3, Jan. 1956, pp. 428-32.

give him affection for his own sake, but rather it appears that most adults involved were hopelessly entangled by their own personal feelings about the matter.

Next, Mrs. Bostock describes the desperate seeking of advice and help for their child, sometimes, we might add, a seeking for only the kind of information which they wished to hear. Their first professional advisor was the family doctor who may have had the courage to tell them about mental deficiency but then often advised them to send the child away and forget they ever had him. Many parents were referred to other consultants and clinics until finally they received much the same advice. Those who accepted the advice, for the good of the child and the family, soon found that entry to a government institution required a court procedure. They had to declare the child incompetent and to deny themselves the right of jurisdiction as they placed him in the hands of a governing body. At the institution they found a staff, limited in numbers, and often in understanding, who were so busy caring for the children that little help could be given to the anxious parents. Even parents who were willing and able to keep up an interest in helping the child were actually discouraged by the staff who often could only see this as another interfering factor in an already demanding job.

Some parents decided to keep their children at home as long as possible, but they too were met on all sides by discouragement, criticism and frustration. It was a constant struggle to combat public opinion, to protect the child from open ridicule, and to try by any method to provide for him some of the things to which he was entitled.

In this emotionally highly charged atmosphere a very real problem arose whereby those who had sent their children to an institution directed some of

their strong feelings surrounding such a decision to actual criticism of those who kept their child at home. Parents who were making many sacrifices in order to keep their defective child at home felt that the others were shirking their duty. Thus, parents of the mentally deficient were often denied even help and comfort from each other.

During the last few years many advances have been made in the areas of public understanding, professional practice, and parent education and action. Yet these are only recent developments and, as described above, many parents have been subjected to harrowing experiences over the years so that for these people it will be a long struggle in returning to active co-operation with the newer and more progressive programs. This concept of change in outlook and program with its accompanying problems, will be more fully dealt with in the following section on historical background.

In the hope of achieving better understanding of the problem and as a guarantee that the vast needs, as sketched out, would be met by society, the White House Conference set forth the rights of the handicapped child:¹

"A Bill of Rights for the Handicapped Child:

1. To as vigorous a body as human skill can give him.
2. To an education so adapted to his handicap that he can be economically independent and have the chance for the fullest life of which he is capable.
3. To be brought up and educated by those who understand the nature of the burden he has to bear and who consider it a privilege to help him bear it.

1. - - - - - "The Handicapped Child"; White House Conference on Child Health and Protection; The Century Co., New York, 1933, p. 3.

4. To grow up in a world which does not set him apart, which looks at him, not with scorn or pity or ridicule - but which welcomes him, exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.
5. To a life on which his handicap casts no shadow, but which is full day by day with those things which make it worth while, with comradeship, love, work, play, laughter, and tears - a life in which these things bring continually increasing growth, richness, release of energies, joy in achievement."

Historical Background of Mental Deficiency

Interest in the care of the mentally deficient has a continuous thread leading back through over a thousand years of history. It was early in the seventh century that the mentally deficient began to seek refuge at the shrine of St. Dymphna in the ancient Belgian village of Gheel.¹ From these early beginnings, the village of Gheel has become a world famous colony to which the mentally deficient as well as the mentally ill from many lands come to avail themselves of the family system of care and treatment for which it is noted. Gheel was, however, a rather solitary light shining through the darkness of the middle ages when the "village idiot" continued to be the scapegoat and the mental defective generally received a harsh, inhuman, and sometimes hostile treatment.² The mentally defective were not separated as a group from the mentally ill and only the severely defective, the idiots, were identified. At the hands of the community they all suffered the lot of "paupers"

1. Zilboorg, G; A History of Medical Psychology; Norton and Co.; New York, 1941.

2. Deutsch, Albert; "The Mentally Ill in America"; Columbia University Press; New York, 1949, pp. 333-336.

and were put in the almshouse along with other unfortunates, the sick, the infirm, children, and the insane. In America in the Eighteenth and Nineteenth Centuries a crude alternative to the almshouse known as the "New England System" was popular.¹ This was a method by which the local government boarded out the wretched paupers as cheaply as possible at an annual public auction. The paupers, men, women and children, were lined up on the auction block for inspection, particularly with regard to potential labour value. The citizen who offered a year's support for the least cost to the community won the bid and the pauper became a kind of slave for the year. Some attempts were made to regulate the care given but, as a whole, the individual was open to great abuses.

In 1798 a curious happening led to a series of events which, as Deutsch points out, were of the utmost importance to the whole field of mental deficiency.² It was in that year that a group of sportsmen, hunting in the forest of Aveyron, France, encountered a boy living in a wild state, roaming naked through the woods and subsisting on roots and nuts. He was captured and taken to Paris, where he was examined by Dr. Itard, chief medical officer of the institution for the deaf and dumb.³ The discovery of the "savage of Aveyron" aroused great interest throughout Europe at a time when there was much discussion about the philosophy, theory, and reform of education. Here, it was believed, was the chance to study the development of an untutored savage who had been untouched by civilization. Fortunately, Itard held with this theory and began to work patiently with the boy using methods suggested by Locke and Condillac who had pointed out the relation between sensory fac-

1. Ibid. pp. 116-120

2. Ibid. pp. 336-338

3. Loc. Cit.

ulties and learning. By the time Itard was finally forced to admit that the boy was really an idiot, he had already brought about considerable improvement in his patient. He then continued his study of the boy for five years, working out training principles for the idiot group, an experiment he would never have undertaken except for this remarkable occurrence at Aveyron.

Dr. Itard handed on his researches to young Dr. Edouard Seguin who then entered into a life-long career in the study and care of the mentally deficient.¹ He developed a system of training which had the aim of bringing all the senses and organs to their maximum function in order of physical, perceptual, and finally conceptual training. Seguin looked upon the individuals' life expression as being made up of many functions, each of which was directly related to a given bodily sense or organ. By training each of these to the maximum of its capacity and in relation to the others, they would achieve a harmonious whole. The mentally deficient pupil was first given physical training so that he could learn to co-ordinate and control his body and some senses, with physical handicaps receiving additional attention. Then the training would proceed with development of the perceptual faculties in order to gain maximum awareness and stimulus from the world around him. The pupil would then be in the best possible position to receive and accept the difficult conceptual training. This early academic teaching would again be closely tied in with the previous methods of training. His programs included pleasant surroundings, good diet, correction of physical ills, along with special imitative instruction, vocational training and farm labour. Seguin had laid the firm foundations for training of the mentally deficient. Furthermore, his work had an important influence on general education, while the

1. Ibid. p. 338

study of this group led to better understanding and further study of the needs of normal children.

The work of Seguin and other French pioneers was quickly taken up in other western countries. Thus, in Britain a private school was opened at Bath in 1846 and soon after came the famous public institutions at Colchester (1849) and Earlswood (1855).¹ In America the first state institution was opened in 1848 in Massachusetts, under Dr. Samuel Howe. This school has made many contributions to the knowledge of mental deficiency during its century of operation and continues to be a leading institution in America, it now being known as the Walter E. Fernald School, named after its best known physician.² Dr. Seguin had been active in politics in France and, following the failure of the Revolution of 1848 and the accession of Napoleon III, he crossed the Atlantic to make his home in the United States. There he personally helped to organize three of the first four institutions for the mentally deficient in the United States. Dr. Seguin advocated and became a charter member of the organization now known as the American Association of Mental Deficiency, on June 6, 1876.³

The early schools were founded with much optimism on the belief that most mentally deficient children could be trained and rehabilitated to the community as self supporting citizens, and thus their problems considered to represent a new field of education. Seguin himself taught for a long time that mental defect was curable. Their enthusiasm can be all the more appreciated when it is realized that diagnostic methods were not so precise as today, nor were the community's demands on the individual so complex, so that these

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1. Ibid. p. 340.
 2. Ibid. p. 343.
 3. Ibid. pp. 345-347.

pioneers were actually working with a more seriously affected group, those who were more obviously mentally deficient. Experience proved Seguin's educational methods to be effective, and in fact, they are still used today, but it also taught that the degree of success was dependent upon the intellectual level of the pupil. The early hopes of curing the idiot through special educational methods had to be abandoned and the schools began to limit admission to those in the higher levels who could benefit from this instruction.

The early schools were started on sound principles, often with great zeal in the face of public misunderstanding and derision, and might have continued on their progressive path had it not been for influences soon to come from several directions. Within the schools themselves many pupils were remaining who could not respond to training, while others, who had shown some improvement and were ready for family care, had no resource to which they could return in the community. No arrangements had been made by society to accept these children who could have been returned to their homes with some financial help, or, for example, could have been placed with foster families. Outside the schools the situation was even more urgent, the vast majority of the mentally deficient having no provision for care except the poorhouses and the prisons. This was also a period of history when various other groups of unfortunates were being separated from the poorhouse, such as children and the insane. These pressures were felt directly by the government schools for the mentally deficient and the swing of the pendulum towards custodial care had begun.

The end of the nineteenth century and the beginning years of this one brought forth scientific discoveries of great importance to the world and, in

the study and treatment of mental defect, with unexpected results. Darwin's theories of "natural selection" and Herbert Spencer's "survival of the fittest," which had become widely known, were distorted by others to serve and support the "better" classes and for condemnation of the unfortunates of our society. Then, Mendel's laws of heredity came into general acceptance. In the unsympathetic climate mentioned above it was quickly asserted that mental deficiency followed Mendel's laws and thus was simply the result of bad heredity.

In 1905 Drs. Binet and Simon presented their famous scale for measurement of mental age. It was quickly put to use with modifications which gave the Intelligence Quotient (the ratio of mental age to chronological age) in terms of a percentage of the normal. Surveys were carried out in institutions and later in schools with frightening results. It was thought, from these mental tests, that most of the delinquent, the immoral, and the dependent therein were mentally defective. Then the shock came when tens of thousands of school children were found to be in the same intelligence group. As Duesch puts it, "the moron was being discovered on a vast scale."¹

Mental deficiency, until then, had meant the more severely affected group. This sharper tool, the intelligence test, was now accurately outlining the large group of persons within the Borderline classification, and especially the top level of mental deficiency, the Mildly Deficient (moron) group, whose extent had not been previously realized. It looked as if the Western world were heading towards a chaotic citizenry composed entirely of the feeble-minded.

The alarmist period had well begun and was to last for at least two

1. Deutsch, Albert; The Mentally Ill in America; Columbia University Press, New York, 1949, p. 356.

decades of this century. The eugenics movement became a strong and popular group which soon established heredity as the cause of social problem classes as well as physical illness, and mental illness and deficiency. Published accounts of so-called degenerate families, for example "The Jukes" and "The Kallikak Family", established in the public mind that mental deficiency was "the mother of crime, pauperism and degeneracy."¹ The experts in the field made equally alarming statements, while the eugenics enthusiasts led in the demand for sterilization, and segregation from society.

Sterilization is a large and controversial subject but it may be safely stated that as a eugenic measure it has, on the whole, been disappointing. The original demand was to sterilize all those defectives who were in institutions, but these are the lower groups who, it has been found, are least likely to reproduce.² Kallman, in a discussion of the genetic aspects of mental deficiency, states that the Moderate and Severe groups, if genetically determined, depend upon single major genes and that most of these tend to follow a recessive mode of inheritance.³ This is confirmed by the observation of a higher rate of parental consanguinity in these genetically determined, low-grade groups. Moderate and Severe degrees of mental deficiency are, however, caused mainly by environmental factors (including, infection, trauma, etc.), although there is a possibility that some severe conditions require the interaction of certain environmental circumstances and the effect of a major gene.⁴ Because the etiology of Moderate and Severe degrees of Mental deficiency is mainly a matter of environment, and since the proportion

1. Ibid. p. 360

2. Ibid. p. 374

3. Kallman, F.J.; "Recent Progress in Relation to the Genetic Aspects of Mental Deficiency"; American Journal of Mental Deficiency; Vol. 56 #2, Oct. 1951, pp. 377-379.

4. Loc. Cit.

which is of genetic origin is largely recessively determined, then it would seem to follow that sterilization would be quite ineffective as a general method of control.

The greatest number of the mentally deficient come within the Mild (Moron) classification and within this group perhaps the majority are the result of genetic factors, according to Kallman,¹ Ister,² and Jervis.³ The process is one of multiple genes in which a large number of small differences may act additively to produce, as only one example, Mild mental deficiency.⁴ This, however, is not a genetic problem by itself but is only a segment of the total structure of intellectual inequalities in the general population. High-grade deficiency, then, forms the lower end of the normal distribution of human intelligence.⁵ Again it would seem impossible to apply sterilization measures which would have any appreciable effect on the Mildly deficient group.

It has been suggested that society might best concentrate on improving the environmental factors affecting its members, while continuing the study of genetics. It would seem that sterilization, at the present state of our knowledge, may be best thought of in the individual sense where, for example, children would cause the collapse of a happy, married, adjustment in the community. Thus, Noyes⁶ comes to the conclusion that "sterilization as a general policy is a superficial method of approaching the problem of feeble-mindedness,

1. Loc. cit.

2. Ister, J.; "Scientific Problems, Progress, and Prospects"; American Journal of Mental Deficiency; Vol. 59 #3, Jan. 1955, p. 428.

3. Jervis, G.A.; "Medical Aspects of Mental Deficiency"; Vocational Rehabilitation of the Mentally Retarded; U.S. Government, Washington, 1950, p. 11.

4. Kallman, F.J.; Loc. Cit.

5. Loc. cit.

6. Noyes, Arthur P.; Modern Clinical Psychiatry; Saunders Co.; Philadelphia, 1953, p. 317.

since it ignores the need for special investigation and research as to its cause and prevention."

The hue and cry for segregation of the mentally deficient from society, however, had a more lasting effect on this defenceless group. More custodial institutions were built, and the once progressive curricula sank to a new low. Society had thoroughly rejected these children, placed a stigma on both the child and parent, and decreed that the mentally deficient remain away from, and out of sight of, its citizens. It was never possible to segregate the whole group as intended and no more than one-tenth have been institutionalized.¹ However, the barrier to progress was most effective and persistent.

These attempts at solving the problem by single answer, wholesale methods failed because of the very nature of mental deficiency. It is now recognized that it covers a heterogeneous group of conditions having widely varying causes and calling for widely different methods of prevention and treatment. The earlier fears about the menace of mental deficiency have gradually subsided as public issues to be replaced by more constructive attitudes. This is exemplified by Penrose² who ably refutes this fear from his biological point of view and demonstrates genetically that the population is in equilibrium. He asserts³ that the idiot is now seen as an integral part of the human race in its struggle for evolution and survival, that subcultural mentality is the inevitable result of normal variation, and moreover, that some of these groups make as strong a contribution to the race, genetically

1. - - - - Social Work Yearbook; Russell Sage Foundation, New York, 1949, p. 323.

2. Penrose, L. A.; "The Supposed Threat of Declining Intelligence"; American Journal of Mental Deficiency; Vol. 53, July 1948, p. 118.

3. Penrose, L.S.; The Biology of Mental Defect; Grune and Stratton; New York, 1949, p. 240.

speaking, as do the highly intelligent who contribute in fewer numbers.¹

Definitions and Concepts

Tredgold² in his definitive text book notes that mental deficiency must first be differentiated from the other two abnormal conditions of the mind namely mental disorder, which includes the psychoses and psycho-neuroses, and mental decay in which are various types of dementia as, for example, in senility. Mental deficiency is a condition in which the mind has failed to reach complete or normal development. He comes to the conclusion that:

"The essential purpose of mind is that of enabling the individual to make a satisfactory and independent adaptation to the ordinary environment of his fellows; it would be intolerable if a person able to do this, to earn his living and manage himself and his affairs with reasonable prudence and efficiency, were to be stigmatized as defective, and subjected to control, merely on the ground of illiteracy and poor scholastic attainments, or because he failed to come up to some arbitrarily fixed intelligence quotient. Hence, I regard the social as not only the most logical and scientific concept of mental deficiency, but as the only criterion which the community can justly impose.

We have now to see what is the legal conception of mental deficiency. I think it is clear that the view taken by the English legislature, and the one which is coming to be generally accepted in most other countries, is identical with the social concept just described. The Mental Deficiency Act of 1927 says 'mental defectiveness means a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury.'³

1. In this section an attempt has been made to trace briefly the historical aspects of the care of the mentally deficient. In following this particular thread of society many important and provocative issues have been passed-by with only the briefest mention, such as Social Darwinism, differential fertility and intelligence, and eugenics. The reader, therefore, is referred to some suggested major sources as follows:

Carr-Saunders, A.M.; Eugenics; Williams and Norgate Ltd., London, 1926.
Hobhouse, L.T.; Social Evolution and Political Theory; Columbia University Press; New York, 1911.

MacIver, R.M.; Community, a Sociological Study; MacMillan and Co.; London, 1928.

MacIver, R.M.; Society, a Textbook of Sociology; Farrar and Rinehart, Inc.; New York, 1937.

2. Tredgold, A.F.; A Textbook of Mental Deficiency; Baillierre, Tindall and Cox; London, 1952, pp. 1-6.

3. Ibid. pp. 5-6

Tredgold then affirms from further study of the British Act that the legal concept is again "that of a degree of arrest sufficient to prevent independent social adaptation and necessitate some form or degree of external care."¹ In Britain mental deficiency is determined by two different methods according to the individual's age. Children to be reported to the Mental Deficiency Authority are:

- (1) "Any child above the age of two years who is found incapable of receiving education at school.
- (2) "Any child in attendance at school who, by reason of a disability of mind is likely to require supervision after leaving school."²

In this manner the social criterion of our definition is met, in children, by examining the child in the light of what degree of social adjustment can be expected of him in the future. Tredgold makes a strong plea for the reporting of every such child to the Mental Deficiency Authority in order that he can be protected and helped by the legislative provisions.

The diagnosis of mental deficiency in adolescence and adult life can only be made, Tredgold continues, after a full inquiry is made into the persons' life history, including his ability to work, how he had looked after himself and his affairs, investigation into the extent of his general knowledge, scholastic ability, and such. Two questions can then be asked - "(1) Does the individual require care, supervision, and control either for his own protection or for the protection of others? (2) Is such care needed by reason of mental defect existing from before the age of eighteen years? If both answers are in the affirmative, then the person is a mental defective within the meaning of the Mental Deficiency Act."³

1. Loc. cit.
 2. Ibid. p. 431
 3. Loc. cit.

Sometimes persons display a lack of knowledge and ability, along with a kind of behaviour which has all the appearances of the feeble-minded but which is due to factors other than mental defect and thus does not come within our definition above. This is known as pseudo-mental deficiency (or pseudo-feeble-mindedness) and is an apparent intellectual impairment within an individual who actually still possesses the potential for future mental functioning. The condition may be particularly difficult to identify in children who have never shown an earlier stage of normal behaviour. Many are handicapped by sensory defects or physical conditions, such as blindness, deafness, and spasticity which isolate them from the usual stimulation and information. Others are suffering from juvenile forms of mental illnesses, which are just now being studied. In a recent article,¹ Dr. Leo Kanner is quoted as concluding lately that these children have been reared in "an emotional refrigerator."²

Similarly then, perhaps the largest group of the pseudo-mentally deficient comes under the heading of emotional causation. The child may fail to progress because of emotional reactions such as fear, rebellion, self-punishment, or a desire to return to the infantile state. This is further discussed with most interesting examples by John D. Macdonald in a monograph from the Ryther Child Centre.³ For our purposes it will suffice to confirm that pseudo-feeble-mindedness does not come within the definition of mental deficiency. However, emotional factors can and do play an important part in any child's adjustment to life, not least in the care and training of the mentally deficient.

It was mentioned earlier that the invention of the intelligence test

1. Katz, Sidney; "The Lonely Children"; Maclean's Magazine; Toronto, Vol. 69 #2, Jan. 21, 1956, p. 12

2. Ibid. p. 49

3. Macdonald, John D.; "A Study of Three Cases of Functional Feeble-mindedness"; Monograph III, The Ryther Child Centre, Seattle, 1948

brought forth a new understanding of the distribution of intelligence and the incidence of mental deficiency. Although the social concept remains as the critical factor in determining a condition of mental deficiency, the measurement of intelligence can then be used successfully to help in grading the individuals in the group. The Intelligence Quotient to be used as the dividing level between the Borderline Group and the Mentally Deficient has been chosen by Tredgold,¹ Burt,² and Penrose³ as I.Q. Seventy, while the American Association on Mental Deficiency has been considering I.Q. Seventy-five.⁴

Penrose explains that in addition to being a practical figure that fits closely the definition and practice, I.Q. Seventy is also the point on the theoretical normal distribution of intelligence below which a score would be considered exceptionally or abnormally low. This borderline figure is mainly useful as a matter of convenience, and it must always be remembered that for the individual this is a flexible level which is related directly to his own adequacy of functioning. For a further discussion of classification the reader is referred to the 1954 Progress Report of the Special Committee on Nomenclature of the American Association on Mental Deficiency.⁵ Before setting out their classification they too warned that an adequate quantitative figure could only be set after observations, histories, and related findings

1. Tredgold, A.F.; A Text-Book of Mental Deficiency; Bailliere, Tindall and Cox, London, 1952, p. 428

2. Burt, Cyril; The Subnormal Mind; Oxford University Press; London, 1955, p. 92 and 156.

3. Penrose, L.S.; The Biology of Mental Defect; Grune and Stratton; New York, 1949, p. 25.

4. Sloan, W.; Chairman, "Progress Report of Special Committee on Nomenclature, A.A.M.D." American Journal of Mental Deficiency; Vol. 59 #2, Oct. 1954, pp. 350-351.

5. Ibid. p. 345

about the individual, in addition to psychological test scores, were carefully studied. It added that the degree of defect remained relative to cultural norms and stresses, and was modifiable.¹ This recent classification by the American Association is similar, with the exception of the upper limit of seventy-five, to that in use at The Woodlands School. (This training school will be discussed later in section three of Chapter Four.) It is this latter scheme which we will adopt.

The classification, for our purposes, (with earlier terms in brackets) will be as follows:

Borderline Group:

Borderline	I.Q. 70-90	(Dull Normal) (Borderline)
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Mental Deficiency:

Mild	I.Q. 50-70	(Moron)
Moderate	I.Q. 25-50	(Imbecile)
Severe	I.Q. 0-25	(Idiot)

Although this classification appears to be simple enough, there have been endless divisions for specific purposes and a confusing array of terms. "Feeble-mindedness" means, in America, the whole range of mental deficiency while in Great Britain it refers to the classification of moron only, and this practice has become synonymous with mental deficiency and, strictly speaking, it is a misleading term. Burt² spoke of retarded children in describing the educational progress of mentally deficient children but he hastily added "However, this must not be taken to imply that the backward child in the end will catch up." "Mentally retarded" has become a popular

1. Ibid. p. 350.

2. Burt, Cyril; The Backward Child; University of London Press; 1937, p. 7.

term with all parents' organizations, to the exclusion of others, so that it now appears frequently in the literature.

The causation of mental deficiency will be discussed very briefly in order to give the present beliefs regarding its heredity and also to point up the complexity of the general group.¹ The first causes are those due to heredity and, according to the best evidence available, heredity causes account for approximately thirty percent of mental deficiency.² This is only a fraction of the earlier, alarmists estimates. Of this heredity group the greater proportion are only mildly deficient. The remainder are divided into over a dozen clinical entities and although comparatively few in numbers they may be severe in degree, with accompanying physical abnormalities.

In the second group are those due to environmental causes, that is, during pregnancy, birth, and the childhood developmental period. There are various infections which strike before or after birth, for example, measles via the mother, and encephalitis in childhood, each with its particular type of damage. There are defects due to trauma and toxic agents at many stages and included is Rh incompatibility. Finally, disorders of the endocrine glands with their intricate functions are believed to account for several types of defect. It can thus be seen that mental deficiency is the result of many different ills which, each in its own complex way, has caused a defect in mental competency.

Methods of the Study

It is the purpose of this study to furnish background information on men-

1. Jervis, G.A.; "Medical Aspects of Mental Deficiency"; Vocational Rehabilitation of the Mentally Retarded; U. S. Government, Washington, 1950, pp. 1-17.

2. Noyes, A.P.; Modern Clinical Psychiatry; Saunders Co.; Philadelphia, 1953, p. 299.

tal deficiency, including some approaches towards solution of the problem by other countries, leading to a description of the present state of services for the mentally deficient in British Columbia.

Some major trends towards furnishing a comprehensive and statewide plan for the mentally deficient in Great Britain and in America will be reviewed under five general headings:

(1) Identification of the mentally deficient in the state and provision for diagnostic and parent guidance facilities.

(2) Home Care and Family Services will include services to the family in the home, parent organizations, and provisions such as day care centres.

(3) Education, Training, and Custodial Facilities will embrace a discussion of public and private education, community or state institutions and occupational training.

(4) Rehabilitation to the community in the broad sense will involve such areas as family care programs, provision for employment, sheltered workshops, social and recreational facilities, continued supervision.

(5) Personal Training and Research. The urgent needs in these areas will be outlined.

The British Columbia setting will be described and an estimate made of the numerical extent of the problem in this province.

Services to the mentally deficient in British Columbia can then be described under the previous five general sections. From this, conclusions can be drawn and some recommendations made regarding present and future provisions for care of the mentally deficient in British Columbia.

CHAPTER 2

THE PATTERN OF CARE IN GREAT BRITAIN

Historically speaking, it will be remembered that both the United States and Great Britain began in the second half of the last century to make provisions for the mentally deficient and hopes ran high in the new residential schools with their equally new educational system. This was followed by the periods of disillusionment and then actual hostility and fear on the part of the public who effectively segregated these unfortunates from society. In America this pattern of institutional care continued on with little change right through the nineteen twenties, the years of the Great Depression, and the Second World War. In contrast, the past ten years have seen a quickening of interest throughout the nation, affording unprecedented opportunities for the mentally deficient.¹ It was even more recently that a national parents' group was established which quickly became a powerful influence for progress. In America the care of the mentally deficient is the responsibility of the individual State so it is not surprising that some of the older and richer members made steady advances in such areas as institutional care, education and training. However, there continued to be a lack of general participation by individuals and groups within the community in the care of the mentally deficient.

On the other hand, Great Britain began this period with a framework of legislation which included provisions for care in several types of institutions and under various forms of guardianship, including private family care.

1. Roselle, E.N., Chairman, "Report of Committee on Administration, American Association on Mental Deficiency, May 24, 1955."; American Journal of Mental Deficiency; Vol. 60 #3, Jan. 1956, p. 661.

Much responsibility lay with the local governments and from this arose a complex pattern which featured participation by many voluntary organizations in the areas of both care and education. The years following the last war have seen revolutionary advances in social services, education, and health, which have had far-reaching effects for the mentally deficient.

Trends in Great Britain

Social services had long been accepted in Great Britain as a natural benefit available to citizens of the state, when, during the recent war years, the further idea of social security for all "from the cradle to the grave" was first given official expression. This was the famous Beveridge Report on "Social Insurance and Allied Services", 1942¹. Its recommendations were to be built upon a foundation of three basic services: a system of children's allowances, comprehensive health and rehabilitation services for all, and control of unemployment. It looked forward to a wide policy of social progress to be achieved by co-operation between the individual and the state. Many of these outlines have now been filled in by legislation which provides for family allowances, insurance against injury and unemployment, and state-wide town and county planning. Similarly, the National Assistance Act, 1948, removed the last traces of the old Poor Laws by providing a nationally operated scheme of financial help from central funds.² The setting of standards and re-organization of care for children was done in the Children Act, 1948.³ These trends towards nation-wide care and responsibility for those in need have considerably influenced the care of the

1. - - - "Social Services in Britain," Central Office of Information, London, 1954, p. 5.

2. Ibid. p. 6.

3. Loc. Cit.

mentally deficient.

The main legislation concerning this group is still the Mental Deficiency Act, 1913 to 1938, but its objectives have been given far greater scope and effect through the provisions of the new and comprehensive National Health Service Act, 1946, and the Education Acts, 1944 to 1953. The Mental Deficiency Act defines four classes of defectives, namely idiots, imbeciles, feeble-minded and moral defectives, and sets out the forms of care.¹ Firstly, Institutional care may be provided in State Institutions for the "criminal or dangerous", Certified Institutions for public custody, Certified Houses for privately paid custody, and Approved Homes which can keep patients on a voluntary, unrestrained basis only. Secondly, there is Guardianship by a suitable person appointed by judicial authority, and thirdly, Supervision by local officials or associations. Overall responsibility for the supervision and protection of the individual defective, as well as inspection of places of care is held by the Board of Control which works through the Ministry of Health. The Local Authorities, at the county level have certain duties in identification and registration while the Local Educational Authorities have further duties towards the school age defective child. Finally, the Regional Hospital Boards under the National Health Service Act are required to provide sufficient accommodation in institutions. It should be noted here that the above legislation applies to England and Wales, while separate enactments provide similar services to Scotland and Ireland. With this legislative and administrative outline in mind, the care and opportunities available for the mentally deficient and their families can next be discussed.

1. Tredgold, A.F., A Textbook of Mental Deficiency; Bailliere, Tindall and Cox, London, 1952.

Identification

The majority of mental defectives first come to official notice in the schools¹ where the child is faced with the normal demands for his age group for the first time. Furthermore, the Education Act specifically makes it the duty of the Local Educational Authority to ascertain all children who need special educational treatment, from the ages of two to sixteen years.² School Welfare Officers, a group whose services evolved from truancy-policing duties to a true liaison between school and home, now take on important functions of identification. In the course of visiting all families who have not sent their five year old children to school, the Officer may suspect mental deficiency and the child is referred to the School Clinic. The parents of such a child over two years of age not only have the right to have their child examined but they may, under the Education Act, be required to have the child examined when requested to do so by the proper authorities.³

The Local Authority is required by the Mental Deficiency Acts to ascertain what persons within its area are defective, under certain categories.⁴ These include persons subject to neglect or cruelty and those involved in crimes or imprisonment. The parent also may refer a child who is in need of care and training beyond home facilities, while the schools may refer children who are ineducable and those who will require supervision after leaving school.

In Great Britain the child welfare centres, which we would call well-baby clinics, have become universally popular and have thus become an important

1. - - - - "Social Work and the Social Worker in Britain"; Central Office of Information; London, 1951, p. 48.

2. Op. cit. p. 468.

3. - - - - "Children in Britain"; Central Office of Information; London, May, 1953.

4. Op. cit. p. 460.

referral agency for the mentally defective. Other sources include hospitals, family doctor, relatives, friends and the courts. Parallel advances in child welfare under the Children Act, 1948, have included registration of all children in care or requiring special services which has become another method of referral. Thus it can be seen that measures have been taken to ensure that a large proportion of the mentally deficient in the country are identified at an early age.

Diagnostic and planning services are most important as they form the base of any program for the mentally deficient. A system of Child Guidance Clinics is being built up from the previously separate facilities of psychiatric department of general hospitals, local health services and school clinics. The responsibility is divided between the Ministries of Health and Education but in practice joint clinics have often been formed. Here the professional team of psychiatrist, psychologist, and social worker carefully studies all aspects of the child's development in the light of his environment and family background, makes a diagnosis, and in co-operation with the family, a plan for the child is made. Many clinics provide continuing treatment for emotional maladjustments of the child, and offer guidance to the parents as well. There are travelling clinics in some areas, while others supply extensive transportation facilities so that the client can go to the clinic regularly for treatment. Psychiatric social workers may also take services directly to the home. The important function of the Child Guidance Clinic appears to be generally appreciated, as indicated by the growth of the system and the endeavour to make these services available to all.

Home Care and Family Services

British parents have traditionally been encouraged and helped to maintain their defective child in their own homes. This has been achieved both through

specific legislation and services, and by support of the generally advanced educational and welfare services. The primary need of the mentally deficient child and his family who are providing such care, is a guarantee that guidance and supervision will continue throughout his life, regardless of what the future may hold for the individuals concerned. In this respect the legislation does recognize that mental deficiency is a long term condition in which the person may require varying degrees of care and protection throughout his life. The Mental Deficiency Acts provide for not only institutional care but the State also assumes considerable responsibility for care in the home by means of Statutory Supervision and Guardianship.

Statutory Supervision is an official recognition that a person is mentally deficient and, following such registration, the Local Authority undertakes to provide continuing services. Social workers or health visitors make regular calls to the home to see that the person is being properly cared for and to give help and understanding in the difficult problems that arise in the handling of the mentally deficient. Guardianship, goes a step further and is an order of a judicial authority which delegates guardianship to a suitable person, with over-all supervision by the Board of Control. This may be applied to the parents of the mentally deficient which then empowers the local authority to provide financial assistance up to the entire cost of his maintenance. In addition to these provisions, the Mental Deficiency Act also requires the Local Authority to provide suitable training, or occupation for those under supervision. The parents can expect understanding and expert help in meeting the problems of mental deficiency, with financial help where necessary, and can care for their child in the home, secure in the knowledge that the resources of the state stand by in case of emergency. The mentally

deficient child is guaranteed proper care for life, with his own family where possible, while also available is a wide selection of institutions, training facilities and places where he can do useful work.

The Education Authority makes appropriate schooling available nearby wherever possible, spends a good deal on transportation, and often provides visiting teachers for academic instruction and educational parent guidance in the home. Voluntary children's care committees are a feature of English Schools by which voluntary workers visit the homes to deal with matters affecting the welfare of the child outside the school curriculum, and are often directed by a social worker.¹

In England the main voluntary organization is the National Association for Mental Health.² It brings together the interested public, professional workers, and government observers, with some grants-in-aid from the Ministry of Health. The Association is active in several fields of mental illness and mental deficiency. As a training body it conducts special courses for professional workers which have become national standards, and provides lectures to the public. To the parent of a mentally deficient child it offers help in the problems, and advice in making best use of the many local facilities available. It provides an information and library service, and makes its views known on legislative and administrative matters. The Association is also active in practice and has itself opened several homes and special facilities. It employs a staff of psychiatric social workers who act for certain local authorities in providing preventative and after-care services in the community. Opportunities for more direct participation and support is

1. - - - - "Education in Britain"; Central Office of Information; London, July 1955.

2. - - - - "Social Work and the Social Worker in Britain"; Central Office of Information; London, October 1951.

being provided by a parents' association. The National Association of Parents of Backward Children, with headquarters in London, is opening many branches and growing rapidly. To the North, the Scottish Association for Mental Health has led in setting up occupational centres for the mentally deficient, provides employment services, and offers help and friendship to this group.

Other areas of social legislation have strengthened the home and family and thus its ability to care for the mentally deficient member. The National Assistance Act relieved local areas of financial responsibility for the poor and it would seem that the Local Authority should now be better able to provide for special groups such as the mentally deficient. Housing and community planning legislation will enable more families to provide proper home care. More directly, the National Health Service provides full medical attention, thus relieving the family of a heavy burden which might otherwise have been a factor in deciding against home care. However, beyond these various material aids, perhaps the greatest single feature of Great Britain's program is not only the emphasis on good care in the home, but rather the State's willingness to assume a real measure of responsibility for the mentally deficient by providing supervision and guardianship throughout his lifetime.

Education, Training and Custodial Facilities

Fresh impetus to the work which had been done in the past for handicapped children was given by the Education Act, 1944. In a publication from the Central Office of Information it is stated that the general duty laid upon every Local Education Authority to provide a sufficient variety of primary and secondary education to suit the different ages, abilities and aptitudes of the children in its area was reinforced by a specific charge to have regard to the needs of pupils suffering from a disability of mind or body, and to

provide special educational treatment for them; and by a further duty to find out what children in their area required such treatment.¹ Thus the school medical officer is now required to determine whether children are educable or uneducable in a school provided by the Education Authority.² If the child cannot make use of education, then he must be reported to the local Mental Deficiency Authority; if he is capable of being educated, then the Educational Authority must provide the type of facility that he needs.

Of the group who can pursue academic studies on a limited scale there are pupils of Borderline Intelligence (I.Q. 70-90), by our definition, who can nearly all be placed in "Backward" classes of the regular schools. Those of approximately I.Q. 55-70 can usually best be placed in a Special School where the child can proceed at his own pace under skilled leadership. Special Schools teach the primary academic subjects until, ideally, the child is thirteen years of age. Importance is also placed on arts and a crafts of a creative nature, along with music, drama, dancing and recreation. It is recommended that at adolescence a definite break should be made, at which point the child can then enter a Secondary (Special) School where, the emphasis would be on activities and studies closely geared to the approaching realities of adult life. Thus there would be manual training, domestic science, character and citizenship training with opportunities for student leadership and direction in the school, and religious education.³

In practice, however, there is at present a shortage of nearly all kinds of special schools provision. In England and Wales, December 1952, there

1. - - - - "Education in Britain"; Central Office of Information; London, July 1955, p. 25.

2. Tredgold, A.F.; A Textbook of Mental Deficiency; Bailliere, Tindall and Cox, London, 1952, p. 427.

3. - - - - "Pupils with Mental or Educational Disabilities"; A Report of the Advisory Council on Education in Scotland; H.M.S.O. Edinburgh, 1951, pp. 40-41.

were 20,020 educationally subnormal children attending Special Schools, while the waiting list had reached the total of 12,500.¹ Scotland has been encountering difficulties with its sparsely settled rural areas, and ^{nowhere} near-inaccessible mountain regions. It was estimated that in 1948 more than forty percent of the mentally deficient children were not receiving the special education treatment they required.²

The Scottish Advisory Council, which was mentioned above, firstly recommended that special day schools be provided wherever possible with small classes, and school enrollment of about 150 pupils. Where this could not be done as, for example, in the one-room rural school, the teacher should receive increased help from Travelling Child Guidance Clinics in the matter of identification of the mentally deficient and in the handling of these children. The Council held a firm belief in the child's need for home and family life and so recommended secondly that transportation be provided whereby the child could attend a centrally located special school, or all-age class. Failing this, they stated, provisions should be made for the child to reside in a foster home, or a small hostel, where he could attend a special day school. In the final resort there should be a residential, cottage type school available for him where he could receive educational services and a good living experience. It was noted that a lack of such facilities sometimes resulted in a child being sent to an institution for the more severely mentally deficient, which was deplored. The Scottish Advisory Council pointed out the urgent need for residential schools to care for those mentally deficient children whose homes are gravely unsatisfactory, or who are them-

1. - - - - "Training and Supply of Teachers of Handicapped Pupils"; H.M.S.O., London, 1954, p. 39.

2. Op. cit. p. 36.

selves emotionally disturbed.

It is important to note that the Education Act of 1944 does not register these educable children as mental defectives but calls them educationally subnormal. However, a large proportion of these children are certifiable and Tredgold¹ emphasizes the duty of the schools to inform the Mental Deficiency Authority of all children who will require supervision on leaving school, as such notification makes the child eligible for all the after-care services. The other group, the ineducable, are immediately made known to the Local Authority and are placed under supervision according to the provisions of the Mental Deficiency Act.

The Educational Authorities are still interested however, in the ineducable child. Provisions for the ineducable child are made in Occupational centres where those of I.Q.'s about 40-55, who have failed their trial at special school, may receive training. These centres were originally operated by voluntary organizations in private houses, church halls and the like. The new Education Act provides for subsidization of these centres, opening of new ones and incorporates this service into the overall scheme. These trainable children are taught personal care and hygiene, simple crafts, and especially are given help towards socialization and expression such as music,, dancing, and games. They may be helped to understand certain everyday warnings and directional signs and conventions, and carry out simple domestic and manual tasks. When the child reaches 16 years of age he leaves the jurisdiction of the Education Act and some local areas or voluntary associations provide Occupational Workshops where the ineducable person may work and earn in woodwork, handwork, knitting machines and simple manual tasks. These centres not only train the child but also render the valuable service of

affording parents a respite from the duty of meeting the demands of these children.

For mental defectives requiring institutional care there are the four different classes of establishments. The State Institutions care for the criminal or dangerous defectives, while the bulk of the group are cared for in Certified Institutions, under the Regional Hospital Boards. Privately supported premises are Certified Houses and Approved Homes, the latter receiving voluntary patients only. In addition to care and protection, these institutions provide education, training, socialization, and preparation for return to the community wherever possible.

Vocational training should be available to all educable mentally deficient persons when the special school system is completed in Great Britain. The Education Act of 1944 recognized officially for the first time that the educational process was a continuous process through which all young people would pass. Secondary education will be more universally provided for this group with emphasis on vocational training at the Special Schools.

Rehabilitation to the Community

In order to become established in the community the mentally deficient person almost invariably requires a family with whom he can live and receive some degree of help and supervision. Those who are fortunate enough to have interested and capable parents may live with them and still receive the benefits of supervision, and where necessary, the cost of maintenance may be paid by the state. For the others a home may be found for them through a family care system.

In Scotland a famous system of family care has been in operation for over

one hundred years.¹ Separate provisions were later made for the mentally deficient and the system expanded until in 1947 Pollock stated that practically 30 percent of the total certified mental defectives were in family care.² The Board of Control was responsible for supervision while the Local Authority paid maintenance at half the cost of institutional care. The most satisfactory placements were rural districts with their less demanding tempo of life. Patients were placed with crofters or small farmers where they shared the family life, its table, and its work. It was found that patients generally responded well to placement in such an accepting environment and practically all enjoyed taking some part in the work on the farm.

Pollock believed that there would be difficulties in applying such a scheme to the large geographical areas of America and saw disadvantages in the lacks of Supervision and opportunities for social activity. Instead of this dispersion method he advocated a colony system of family care, such as the original which still flourishes at Gheel in Belgium.³ This requires establishment of a small infirmary-reception centre in a suitable community, perhaps a small town, following successful interpretation and promotion of the program to its inhabitants. The new foster parents would be given training courses in the care of the mentally deficient and a large number of placements would be made in the surrounding area. Some family-sized custodial units might also be added. He believed that such a colony of family

1. Pollock, H.M.; "Family Care of Mental Defectives in Scotland"; American Journal of Mental Deficiency; Vol. 52 #1, July 1947, p. 85.

2. Ibid. p. 86

3. Pollock, H.M.; "Requisites for the Further Development of Family Care"; American Journal of Mental Deficiency; Vol. 50 #2, Oct. 1945, pp. 326-329.

care, supervised by the state institution or a central agency, would be best for America, although he had much praise for the skilled and devoted Scottish Guardians.

In England the Guardianship Society with headquarters at Brighton has become a huge placement agency with special institutions in Brighton and a large staff of social workers supervising home care throughout Southern England. As a private agency it did pioneer work in after-care services to those returned to the community and originated special workshops. The larger institutions have also done substantial work in rehabilitation of the mentally defective. In the study reported by Badham,¹ over 90 percent of a large group of rehabilitees were successful in adjusting both to foster home life with its requirements of acceptable behaviour, and to the work situation. Of these, about two-thirds became fully self-supporting while the remainder were partially self-supporting. The requirements for operation of the rehabilitation scheme included careful selection with assessment of patients as to their personality structure as well as vocational aptitude. Emphasis was placed on good job placement, in which the knowledge about the patient was related to the work to be done and the personality of the employer. A suitable residence was provided and the placement was followed by skilled supervision. Significantly, the study led to the reorganization of training to be in line with the objective, and pointed out the need for co-ordination of selection, training and rehabilitation under one administrative head. Finally, Badham stressed the importance of dealing with the patient as an individual and maintaining close personal contact through continued supervision.

1. Badham, J.H.; "The Outside Employment of Hospitalized Mentally Defective Patients as a Step Toward Resocialization"; American Journal of Mental Deficiency; Vol. 59 #4, April 1955.

In Great Britain the Ministry of Labour operates Employment Exchanges which include a Youth Service and, particularly, the Disablement Resettlement Officer (D.R.O.). The work of these officers involves close co-operation with medical and local authorities and numerous welfare agencies.¹ They offer vocational guidance and the services of vocational psychologists. The D.R.O. then endeavours to find suitable work for the individual with his handicap. He is helped by the Disabled Persons Employment Act, 1944, which requires most employers of more than twenty persons to reserve a quota of three percent for registered disabled persons. The D.R.O. may recommend the applicant for industrial rehabilitation or vocational training, during which the applicant may receive financial assistance. In addition to these services there are provisions for sheltered employment, with some workshope being operated by voluntary organizations with state grants. Thus the mentally deficient person not only receives help from his training school but there are also these special services available to him, and he faces a society which is becoming more aware of the needs of the handicapped.

Social and recreational facilities are a serious problem to the mentally deficient person out in the community. It is not possible for him to take part in many activities and he needs most the understanding companionship of persons who are closer to his own level. He often needs the direction of a supervised recreational program in order to take part in social activities. The Scottish Advisory Council recommended that recreational clubs be provided in connection with the schools, such as is presently done in some of Britain's larger cities. It would appear that the fulfilment of

1. - - - - "Social Services in Britain"; Central Office of Information; London, 1954, p. 18.

this need is left to the voluntary organizations and it is to be hoped that social opportunities will be made available to the mentally deficient.

Personnel Training and Research

The great extension of services to the mentally deficient requires a similar increase in the number of trained persons to carry out the legislation. Teachers of the mentally deficient in special schools are urgently needed, according to the recent report of the National Advisory Council on the Training and Supply of Teachers.¹ To complete the developmental plans of local educational authorities for special schools will require an additional three thousand teachers. The Advisory Council also found that standards must be raised for teacher qualifications. It recommended that all must complete an approved course of training as a teacher, followed by at least two years' experience in ordinary schools. After preliminary experience in a special school the teacher then should undergo special training, a one year university course. The situation in Great Britain is so acute that the Advisory Council had to recommend short courses as a temporary expedient to fill the requirements for new teachers and to bring those in the field up to some standard.

Teachers and other specialists in the field of mental deficiency must also be personally suited to helping this difficult group and be able to bring an understanding attitude to the emotional problems arising from the individual's handicap. The above report showed that the demand for teachers and specialists in the field was tremendous both in numbers and in qualifi-

1. - - - - "Training and Supply of Teachers of Handicapped Pupils"; H.M.S.O.; London, 1954, p. 13.

cations, and recommended financial assistance during training, followed by increased financial reward for the specially qualified. This pattern of great demand, increased qualifications required, and need for higher salaries, as described for teachers, applied equally to the other groups serving the mentally deficient.

The Committee on Social Workers in the Mental Health Services¹ reported that in 1951 England and Wales alone required 1,500 psychiatric social workers, besides a still larger number of other trained and experienced mental welfare workers. The training of these social workers requires a long university course and includes postgraduate study and practice. Unfortunately social work salaries have continued at a low level while the nature of the work makes great demands of the individual. In the light of these requirements it would appear that such a great shortage of social workers will only be overcome by special inducements to those who would be suitable for the work. Probably these would have to include further educational bursaries and generally increased salary scales.

One aspect of training in Britain deserves special mention because of its unique demonstration of a real desire to provide for the child's basic needs, namely, the training of "housefathers" and "housemothers". Britain seems to be well advanced in providing for children in small separate homes where six to twelve boys and girls are cared for by a married couple in a normal home atmosphere. A government agency operates this course in practical care of children and grants a National Certificate.²

From the above discussion it would appear that Great Britain's outstand-

1. "Social Work and the Social Worker in Britain"; Central Office of Information; London, 1951, p. 47.

2. "Social Services in Britain"; Central Office of Information; London, 1954, p. 46.

ing program and further plans for the mentally deficient are being seriously restricted by shortage of specialist personnel. It is noted that the Education Act of 1944 enables the Minister to foster research¹ and make grants to various bodies, and it might follow that further research on personnel problems is indicated.

Summary

In summary, services to the mentally deficient in Great Britain began with the establishment of training institutions in the second half of the last century while during the past fifty years, services have been expanded by legislative means and with the continuing support of private organizations. The years following the last war saw the enactment of comprehensive social legislation which had been forshadowed by the famous "Beveridge Report" of 1942. This trend towards nation-wide care and responsibility for those in need considerably influenced the care of the mentally deficient. General measures ensured the better care of children, financial security for families, and the provision of housing, while the encouragement of town and country planning was directed towards more satisfactory community living conditions for all citizens. The specific legislation included the National Health Act which set up a new administrative system for institutions, established diagnostic facilities, and provided free medical care. The Education Acts placed on the schools certain duties of identifying the mentally deficient and the full responsibility for the education of all children who were deemed "educable". Legislatively speaking, Great Britain has reached an advanced

1. "Education in Britain"; Central Office of Information; London, 1955, p. 13.

stage of development in the care of the mentally deficient. A brief review of the actual services given will point out the extent to which the legislation has been put into effect and places where there is further work to be done.

The key service in any program for the mentally deficient is early identification, diagnosis, and planning with the parents, and Great Britain makes full provision for this in the Education Act. The school system seems to be a logical choice because it is here that the majority of mentally deficient children are discovered in any case, when the child fails to measure up to academic requirements. Similarly, the school liaison officer already has the duty of reporting children who are not sent to school and is thus in a position to refer suspected cases to the clinics for examination. The parents are brought into the planning, and for the sake of the child, may be required by law to present the child for examination. The child guidance clinics, often operated jointly by Health and Education Authorities, are well accepted and give full services to child and family, although the clinic system is still being developed so as to cover all areas. The child welfare centres and other social services have aided in identification. Thus the Local Education Authority is responsible for identifying all mentally deficient children from two years of age to sixteen, while the Local Authority is responsible for the protection of any mentally deficient person who suffers neglect, cruelty, or imprisonment.

Great Britain has traditionally encouraged the care of the child in his own home. The Mental Deficiency Act provides for life-long supervision or guardianship as may be required, thus assuring the parents that their child will receive continued care. The child and family may receive supervisory

visits, financial aid, and complete medical care. Special educational and training facilities are usually available locally with transportation supplied, while teachers will bring training to the home if required. As the child grows up, some provisions for occupational and industrial centres have been made. Voluntary organizations have long been established in this area and additional help is now being offered by the growing parents' organization. In effect, these many and varied services enable the mentally deficient person to function at his best at home, and throughout his lifetime.

Educational facilities for all educable children are now required by law, at both primary and secondary levels, while for the trainable group provisions are made for occupational centres to provide daily training classes. Some occupational workshops are being provided. State institutions have been active in studying their own training programs in order to improve their rehabilitation schemes. Great Britain's educational and training facilities for the mentally deficient are recognized as being outstanding.

Rehabilitation services are also on a high place with long-established family care programs, statutory supervision and guardianship for the individual's protection, and special job-finding resources or sheltered workshops.

Lessons of the British System

The program, as a whole, for the mentally deficient in Great Britain can be cited as an outstanding example of a country's successful solution of the problem, on a national scale. The program is complicated to the extreme, including services on a national level by governments, such as the Ministries of Health, Education, Labour, and the Home Secretary; other bodies such as

the Board of Control; and private agencies such as the National Association for Mental Health. Then, on a local level, representatives of the above agencies work together with numerous local governmental and private organizations in providing for the complex needs of the mentally deficient. At the same time, a great number of persons at the local level are directly concerned with the mentally deficient, which is a strength in any such endeavour. The schemes are set forth in national legislation but much of the responsibility rests with the various local authorities. This is made possible by the extensive background of supporting social services, and probably, by the British tradition whereby the individual citizen is encouraged to take some public responsibility. The gaps in the program as applied to Great Britain would seem to be more a matter of degree than of principle.

The network of Child Guidance Clinics requires further extension, particularly in Scotland, so that all can be serviced. This applies equally to the provision of special schools and occupation centres. It will be remembered that in Scotland some forty percent of children eligible for special educational facilities were not using them, which indicates the need for alterations and extensions to the system as well as interpretation to the parents. To serve sparsely populated areas further residential schools were required. Residential facilities were also needed for the emotionally disturbed child, in preference to state institutions. Further work is required in making available sheltered workshops for the adult mentally deficient person and, equally important, provision of social activities for this older group.

As noted earlier, the whole program is being held back as a result of insufficient specialist personnel including special teachers, therapists, and social workers. Further research, followed by decisive action would seem to be necessary before these serious shortages of specialist personnel are alleviated. In addition, there is need for standardization of personnel qualifications, and general services offered, in order that Great Britain's fine program should be equally available for every mentally deficient person.

CHAPTER 3

AMERICAN EXPERIENCES

As a comparatively young country with vast geographical distances and great differences in stages of development, the United States had produced an equally varied picture in the many approaches to the care of the mentally deficient. Their care is the responsibility of the individual State so it follows that we may be assured of at least forty-nine different ways of looking at the problem. A common idea which has persisted until more recent years is that of segregating the mentally deficient from society so that today no all-embracing, state-wide program has yet been put into effect. In the meantime a great deal of excellent work has been done in a technical way on separate facets of the problem, such as design and function of large institutions, and training and rehabilitation. The writings in the field, also, are found largely in the form of separate articles and conference papers, under the auspices of the professional body, the American Association for Mental Deficiency. There has not been a common framework of legislation and practice such as exists in Great Britain nor, has there been the broad philosophy which enables a real integration of the mentally deficient into the very life of the nation.

An American authority in the field of mental deficiency, Mr. Ernest M. Roselle,¹ Superintendent of Southbury Training School, Connecticut, clearly explained the current American situation and future prospects in an address to the Washington State Convention of the National Association for Retarded

1. Roselle, E.N.; "New Horizons for the Mentally Retarded"; When the State Looks at the Problem as a Whole"; American Journal of Mental Deficiency; Vol. 59, #3, Jan. 1955.

Children, August, 1954. After sketching the outline of a proposed over-all plan for the mentally deficient he stated:

"Ten years ago your speaker would have felt that the prospects of such a program being placed in full operation in any state would have been quite impractical, idealistic and even fantastic. Today he is convinced it can be done in many states. This conviction is based largely, of course, on the potentials which lie in the great national organizations under whose auspices we are meeting in this gathering. This organization has the power to increase public interest and understanding in this problem including procuring the very essential legislation required to implement the program on its several fronts"¹

Identification

Diagnostic and guidance facilities throughout the state are seen by Roselle, as being the keystone of the approach to the problem of mental deficiency as a whole.² Such a clinic for this group could give leadership and co-ordination both in locating the mentally deficient and in helping them to make best use of available resources for care, education and establishment in the community. In the more heavily populated urban areas of the United States the public school systems have provided special classes for children whose I.Q.'s were rated at about fifty and better.³ The more seriously deficient persons sometimes could turn to a Mental Hygiene Clinic but generally these clinics have had neither the time nor the facilities to work with the mentally deficient child and his parents.⁴ Thus, about 1949 the newly formed parents' organizations in the Eastern States found that by

1. Ibid. p. 366

2. Ibid. p. 366

3. Fried, Antoinette; "Report of Four Years of Work at the Guidance Clinic for Retarded Children, Essex County N.J."; American Journal of Mental Deficiency; Vol. 60 #1, July 1955, p. 83.

4. Garber, R.S.; Discussion Leader, "Outpatient Clinic Services for the Mentally Deficient"; Mental Hospitals; American Psychiatric Association, Wash. D.C.; Vol. 7, #2, Feb. 1956, p. 49.

far the greater majority of the mentally deficient were being cared for at home, where they had received only haphazard and inadequate planning and educational services.¹ The first and most urgent project of these voluntary groups was the organization of guidance clinics for mentally deficient children and their parents.

The association for the Help of Retarded Children, New York City, established in 1950 what was believed to have been the first such clinic in the United States designed specifically for the mentally deficient.² The basic team consisted of a pediatrician, psychologist, and psychiatric social worker who made full use of consulting services in the areas of psychiatry, neuro-surgery, orthopedics, speech, endocrinology, physical medicine, and laboratory services. At this clinic the child is studied at play and appropriate tests are administered by the psychologist, while the parents are interviewed by the social worker who prepares the social history. Both child and parents are seen by the pediatrician and the consultants, following which the clinic conference is held. Here a plan of care, training and treatment is decided upon and responsibility placed with the examining pediatrician for directing its course.

Another clinic sponsored by a parents group in New Jersey, this one on a part-time voluntary basis, is described by A. Fried,³ with services similar to above mentioned New York Clinic. Fried reported that the four year experience of the New Jersey Clinic showed successful diagnostic and planning

1. Op. cit. p. 83

2. Feder, Nathan; "The Clinics of the Association for the Help of Retarded Children, Inc."; American Journal of Mental Deficiency; Vol. 56 #2, Oct. 1951, p. 268.

3. Fried, Antoinette, "Report of Four Years of Work at the Guidance Clinic for Retarded Children, Essex County, N.J."; American Journal of Mental Deficiency; Vol. 60, #2, July 1955, p. 83.

services but also pointed up further needs in the fields of guidance and education. It was found that parents required guidance services which would continue after the clinic examination, while the medical practitioner and others in the community who were concerned with the mentally deficient also required further information and help in understanding this special area of practice. [The clinic confirmed that parents of mentally deficient children require special help with personal problems arising from both their own and the community's reaction to the child. The most frequent difficulty encountered was a lack of understanding of the causes of mental deficiency. This lack of understanding led to feelings of guilt and shame within the parents with serious consequences on family and social life, and the parents' own mental health. Secondly, many parents showed rejection of the child with the attempt to cover up by over-protection on the one hand, or by too rigid discipline on the other. In either case the ability of the child to learn to grow up is restricted, and an emotional problem may thus be added to this already handicapped child. Further knowledge on the part of professional people, particularly the family doctor, will enable them to help the child by facing the defect early, and help the parents by understanding their particularly difficult situation.

In America some States have separate systems for the registration of the Mentally Deficient, and in 1930 seven states had such schemes.¹ The beginnings of a more recent state registration, in Rhode Island, are described by Willoughby.² A card file was set up for all those who were diagnosed as

1. - - - - "The Handicapped Child"; Whitehouse Conference on Child Health and Protection; The Century Co., N.Y., 1933.

2. Willoughby, R.R.; "Rhode Island's Experiment in Registration"; American Journal of Mental Deficiency; Vol. 50 #1, July 1945.

mentally deficient by qualified psychiatrists, or all those who were rated below I.Q. 70 by adequate psychometric techniques. The main source of information came from the State Division of Psychometric Services which tests public school children, while other sources were the State School for Feeble-minded, school clinics, hospitals, and other agencies. The total obtained was 7,000 persons or approximately one percent of the population. Information obtained included sex, age, social adjustment, address, degree of defect, family information, marriage, children, physical and ethnic background. To give an idea of the staff required, it was found that once the system was in operation one clerical worker at the registry could maintain, 10,000 cards. These 10,000 mentally deficient persons would represent about one million of the general population.

Willoughby realized the error of declaring a person to be mentally deficient on the basis of psychological tests alone and advocated screening by mass tests in school, followed by a psychiatrist's official diagnosis. The advantages of such registration can be considerable, particularly in the area of research and planning, and Willoughby looked upon it as a minimum essential for intelligent and realistic planning of services. However, there are difficulties involved as shown by the British experience which was discussed earlier. The diagnosis of mental deficiency is a serious matter with long term social consequences. Thus the British decided against reporting the higher grade mental defectives in schools, until it was certain that they would require supervision on leaving school. Furthermore, registration itself has little meaning unless the person is thereby eligible for continued supervision or care. If, however, life-long supervision is available for those who require it, then the registry becomes a control agency which guarantees that these services will continue to be given, thus placing registration

in a more constructive light.

Home Care and Family Services

The philosophy and understanding about placing the seriously deficient child in an institution, as opposed to care in the home, has undergone important changes since 1936.¹ Dr. D. H. Jolly, found that between 1936 and 1948 the number of mentally deficient patients admitted for the first time to United States Public institutions had increased gradually by thirty percent.² However, he continued, the corresponding first admissions under the age of five years had increased to three hundred percent. This great relative increase in the youngest age group coming to the institutions produced a trend which he attributed to three causes.³ Firstly, better diagnostic procedures, such as those provided by the clinics described in the previous section, have provided earlier identification and thus the problem of institutionalizing has to be faced earlier. Secondly, and perhaps this is the most important point, the physicians have been giving increasingly strong advice for immediate institutionalization. Then, thirdly, as a result, more facilities were made available for babies. These additional demands for crib facilities could not be met at the increased rate so that long waiting lists have built up in such institutions. This meant that the parents of a large number of the mentally deficient who were being cared for at home fully realized their children's need for special care and training.

1. Jolly, D.H.; "Where Should the Seriously Retarded Infant Be Institutionalized?"; American Journal of Mental Deficiency; Vol. 57 #4, April 1953, p. 632.

2. Loc. cit.

3. Ibid. p. 633.

In the meantime, Jolly pointed out,¹ much had been learned about the effect of placement on both child and family. Using modern dynamic theories of psychiatry, he showed that it was a fallacy to say that it was best to commit a baby before the mother became attached to it. In most cases the mother was already attached to her child, a process which had been going on throughout pregnancy. It was then necessary for the parents to be with the child for some time to enable them to become "detached", time for full realization of the child's limitations, his need for special care, and time to work out their own emotional conflicts. Furthermore, to recommend an institution when such facilities were not readily available could only serve to place an additional burden of frustration upon the parents. At the other extreme, the child who required institutional placement should not remain in the home so long that he comes to dominate the family, who then could not bear to send him away, for the best time for separation had been passed by. Jolly concluded that there is an optimum time for separation and that this is seldom, if ever, in early infancy.²

It is usually stated that only about one out of every ten mentally deficient persons is cared for in an institution.³ The waiting lists throughout the country are long and have increased with the better diagnostic facilities. As the number of families with a known defective child in the home grew, so did the need and demand for help and guidance in the home. The parents found that there were no public facilities for the home care and training of the moderate and severe groups of the mentally deficient. It

1. Ibid. pp. 633-636

2. Loc. cit.

3. Giliberty, F.R. and Porter, E.L.H.; "Beginnings of a Home Training Program"; American Journal of Mental Deficiency; Vol. 59 #2, October 1954, p. 149.

was this rising number of parents with their better understanding of the services their children required, that led to the formation of the parents' organizations.

Mrs. Dorothy Moss, Secretary of the National Association for Retarded Children is quoted by Wirtz¹ as outlining the growth of her organization. She reported that the first organized parents' association for the benefit of mentally deficient children was formed in Cleveland, Ohio, in 1932. It is interesting to note that this was followed in 1934 by what would appear to be the first statewide parents' group, The Children's Benevolent League of the State of Washington. There were only a few more new groups prior to the second world war but following this the rate of organization quickly increased. The professional people invited parent group representatives to speak at the national conventions of the American Association for Mental Deficiency in 1948 and 1949, while in 1950 the activities and problems of the parents were given a definite place on the program. At this latter convention plans were made for an organizational conference later in the year at Minneapolis, following which the National Association for Retarded Children officially came into being, on February 6th, 1951. In 1953 the secretary reported a total membership of approximately 22,000 with 241 local units, just double the membership of the previous year.²

The parents' groups emerged when individuals became aware of the many problems concerning mentally deficient children which were not being met.

1. Wirtz, M.A.; "The Development of Current Thinking About Facilities for the Severely Mentally Retarded"; American Journal of Mental Deficiency; Vol. 60, #3, January 1956, pp. 499-500.

2. Loc. cit.

In addition to the lack of actual services for their children the parents very much needed the company of others who were faced with similar problems. Thus the special difficulties of caring for such a child and the emotionally charged problems around being parents of a mentally deficient child can each be discussed with others who understand and wish to help. The amelioration of these problems through the group process of sharing and supporting them allows the parents to channel their emotions into healthy, constructive community action. At present in the United States the parents' organizations are setting up pioneer projects across the country to prove the need for, and validity of, special schools, play groups, clinics, workshops, social activities, auxiliary services to institutions, and home training programs. Many of these services, once proven, can be expected to become part of regular governmental programs. Again, in addition to these concrete services, the parent of the defective child is particularly helped by the group's educational services, and in turn many are soon ready to take part in educating the public. This public interpretation of mental deficiency co-ordinated with demands for legislative and community action, has been the outstanding contribution of the parents association. The professional groups work closely with the parent organization at all levels, fully realising that a strong and active parent's group is the best guarantee that the needs of the mentally deficient will be fulfilled by an understanding society.

The increased awareness of the needs of the mentally deficient child has led to the early formation of effective plans for his care, training, and education. In Connecticut, the Mansfield-Southbury Social Service

Department undertakes much of this work which is described by Dudley.¹ There are long waiting lists for institutional care which swells the number who are being cared for at home. The social worker helps the family to make use of available diagnostic clinical services and then to come to an informed decision regarding their own plan for their child. Outpatients services from the training schools can be made available through the worker in the form of consultation, lectures, and home instruction courses at community meetings. Some parents may be able to place their child privately in which case the worker can furnish full particulars of approved homes and schools, and can help to ensure that the family avoids the pitfall of undue financial sacrifice at the expense of parents and normal siblings.

For those parents who will be caring for their seriously defective child at home, there is a Day Care Centre in Hartford, Connecticut, a pilot project carried on and largely financed by the training school.² Here these children may be placed from nine a.m. to five p.m. at a nominal charge. It has been found that mothers had more time for their families and community work, while several obtained employment. The success of this venture has stimulated formation of more such facilities by parents' groups. The day care centre serves to relieve the mother from time to time of the constant demands and responsibilities connected with a defective child, giving her renewed strength to fulfill and enjoy her other roles in the family. In this way the moderate and severely deficient child can enjoy the benefits of family life without adversely affecting the other members. This writer feels that day care provisions can play a key role in the home care of the seriously

1. Dudley, Lois P.; "Home Care Program"; American Journal of Mental Deficiency; Vol. 60 #3, January 1956.

2. Ibid. p. 621.

defective child.

For the trainable child, (roughly, the Moderate group of the mentally deficient), "sub-special" classes are becoming available in Connecticut. Mansfield and Southbury Training Schools, both outstanding institutions in America, offer a Day School program and the social worker refers families to these facilities whenever appropriate and possible. For the older ones Sheltered Workshops are in the planning stage, and there are also special employment provisions. In Connecticut, Dudley¹ reports that recreational facilities include separate swimming instruction, special play areas in parks, daycamps, and a large summer camp in a State Park for the use of institutions and parent groups.

Home care can be further strengthened by bringing training into the home itself. In America, two such programs which have been in successful operation for a number of years, in Massachusetts and in New Jersey, are discussed by Cianci.² The scheme, in New Jersey, was centred in the state training school, and was carried out by visiting teachers. Referrals came first from the Department of Institutions and Agencies and later from schools, social agencies, clinics, and the nursing service. For the grossly defective children emphasis is placed on elementary habit training, emotional control, self-help, speech, and play activities. Visits of an hour and a half are made on the average of once every two months. Teaching methods are explained to the parents along with the understanding that this is a long term process which requires a systematic, established routine with much repetition and perseverance being required. The trainable group are given

1. Ibid. p. 622.

2. Cianci, V.; "Home Training"; American Journal of Mental Deficiency; Vol. 60 #3, January 1956, p. 622.

weekly lessons, again with the participation of both mother and child, in which the child advances to hand work and modified primary studies, which are practised during the intervening week. Household skills are encouraged, both to keep the child busy in a constructive way, and to develop a sense of responsibility and belonging. Companionship was successfully fostered by bringing together two or three suitable children and their parents.

Miss Cianci,¹ of the New Jersey Department of Education, points out that the New Jersey program is carried out by the teachers and that the Massachusetts one is done by the social workers with, she says, the same objectives of better community understanding and better home and family adjustment. She then goes on to explain how parents require insight into their own emotional involvement, and acceptance of the limitations of their child. It seems clear that at this point the functions of teachers and social workers are being lamentably confused. Teachers, especially those who are trained for the mentally deficient, have special knowledge and skills for imparting information, social understanding and philosophy, and other skills, with corresponding training on their use in society, towards the child's growth to maturity. The training of social workers in America does not include such studies and to do so would require complete teacher training.

Social Workers, on the other hand, are prepared with a broad knowledge of the organization of the social services, an understanding of the human behaviour as related to helping people with their problems, and a high degree of skill in one of the methods of social work, in this instance casework with the individual and family. Teachers are not trained in these areas and

1. Ibid. p. 623

should not attempt to practise in them. Fortunately, there should be no difficulty in resolving this confusion over function. Each group should first of all keep within its own area of competency, and secondly have a good understanding of the services given by the other profession. Teachers and social workers should be able to work well together with close consultation between them, and without duplication or confusion. At times a family might require intensive services by the social worker around, say, personal and family problems or decisions, while at others the emphasis might be on the training of the child. Similarly, the parents and child should be able to easily separate these functions in their own minds, as they are already accustomed to doing in the community. To categorize, teachers do Home Training, while social workers are concerned with Home Care. Home care services can be expected to take an important place as the solution of one facet of the complex problem of mental deficiency.

Education, Training, and Custodial Facilities.

Educational opportunity for every child to the limit of his capacity, is the basic philosophy in the United States concerning public education. Roselle¹ points out that this is the right of the child in a democracy and that society clearly has the responsibility to provide the opportunity. Wirtz² reports the ruling in 1929 by the Attorney General of the State of Illinois that a board of education has no legal right to exclude feeble-minded children from school. This was reaffirmed in 1931 and has since been used by parents in their demand for provisions for their deficient children.³

1. Roselle, E.N.; "New Horizons for the Mentally Retarded"; American Journal of Mental Deficiency; Vol. 59 #3, January 1955, p. 367.

2. Wirtz, M.A.; "The Development of Current Thinking, etc."; American Journal of Mental Deficiency; Vol. 60 #3, January 1956, p. 502.

3. Loc. cit.

From the educational point of view there are three groups within the mentally deficient for whom separate and distinct provisions must be made. The Connecticut legislation¹ defines these groups in a clear and acceptable manner. The first group is the Educable Mentally Deficient² which contains those whose expected level of intellectual functioning falls between that commonly expected of a seven year old to that of an eleven year old. This would approximately include the Mild group of mental deficiency. The second group is the Trainable Mentally Deficient whose maximum intellectual functioning would be less than the seven year old, and approximates the Moderate Group of mental deficiency. They must be capable of walking, of clean bodily habits, and of obedience to simple commands. Thirdly, the Custodial Mentally Deficient is not expected to attain clean bodily habits, responsiveness to directions, or means of intelligent communication. They would correspond to the Severe Group of mental deficiency.

In America the first provisions for the Educable group were made in the Eastern States at the end of the last century.³ These became special classes within the regular framework of the public school system. Special classes for the Educable group have now become the accepted principle in the United States, although there is liable to be the usual lag in putting the principle into effect, especially in the more remote areas. In the meantime some states have made it mandatory for educable mentally deficient children of compulsory school age to attend school like the others, for ex-

1. - - - - "An Act Concerning Mentally Handicapped Children"; Public Act 432 of 1953, State of Connecticut, Section 1.

2. "Deficient" is substituted for "Handicapped" to be consistent.

3. Wirtz, M.A.; "The Development of Current Thinking, etc."; American Journal of Mental Deficiency; Vol. 60 #3, January 1956, p. 495.

ample California¹ in 1949 and Connecticut² in 1953.

The latest advance in this area has been the provision of special classes right through the High School grades. In her study of such classes in San Diego City High Schools, Clapper³ notes the success of the program and makes several recommendations.⁴ In these grades, from ten to twelve, the special classes should remain small with specially trained teachers while academic studies should continue. The mentally deficient pupil should participate in all aspects of school life. She recommended a program of vocational guidance, followed by an on-the-job training program, with counselling to pupil and parents as to future planning. This is certainly a true example of the schools endeavouring to help the mentally deficient pupil reach the maximum of his or her capabilities.

The Trainable Mentally Deficient group still requires provision for them in the public schools, and the parents' groups are leading the demand for this service. The developmental pattern of educational facilities for the trainable group is, as Wirtz⁵ points out, following the early historical path which was blazed by the American pioneers in their struggles towards general public education. Many parents groups are being formed with the immediate objective of establishing private classes and schools to train their own children, at their own expense, which forms the first traditional step in the United States pattern of organizing new school facilities. Sec-

1. Martin, M.F.; "The Role of State Legislation, etc."; American Journal of Mental Deficiency; Vol. 59 #1, July 1954, p. 46.

2. - - - - "An Act Concerning Mentally Handicapped Children"; Public Act 432 of 1953, State of Connecticut, Section 3.

3. Clapper, C.C.; "A Study of Mentally Retarded Students in San Diego City High Schools"; American Journal of Mental Deficiency; Vol. 59 #1, July 1954, p. 44.

4. Loc. cit.

5. Wirtz, M.A.; "The Development of Current Thinking, etc."; American Journal of Mental Deficiency; Vol. 60 #3, January 1956, p. 501.

ondly, as the private classes grew into full-scale schools the parents have sought financial assistance from private welfare funds, social organization and clubs, and Community Chests. This development corresponds with the old School Societies of the Nineteenth Century which at times shouldered a large proportion of the educational burden. The final step is public tax support. Arrangements include combinations of local and state responsibility with grants-in-aid being made to the private schools in some cases while in others the governmental authority furnishes the full service.

The experience of the State of Illinois ^{1,2} with the problem of the trainable group should be of special interest to those who are concerned with the growth of educational facilities for the emntally deficient. In 1951 there had been a legislative battle between the parents' groups and the educational organization which was resolved the following year by a unanimous decision to form a two year study project. The educational authorities were charged with the responsibility of evaluating the effectiveness of a public school program for trainable mentally deficient children, while funds were provided for pilot schools.³ The conclusions from the two year experience with the trainable group were clear-cut and, this writer feels, are fundamental to an understanding of this difficult area of education. Baumgartner,⁴ the consultant for this project, observed first that a long term program will be required for the final answers and in the meantime the

1. Ibid. p. 502

2. Baumgartner, B.; "Study Projects for Trainable Mentally Handicapped Children in Illinois"; American Journal of Mental Deficiency; Vol. 60 #3, January 1956, p. 488.

3. Op. cit.

4. Baumgartner, N.; "Study Projects for Trainable Mentally Handicapped Children in Illinois"; American Journal of Mental Deficiency; Vol. 60 #3, January 1956.

study found the public school classes for the trainable group to be valuable if properly established and conducted. Success of the program varied directly with the efficiency of the study and selection of children for the classes. The progress of the pupils was in direct ratio to the capabilities of the special teachers and the degree of understanding supervision provided. The curriculum must be carefully related to the child's potentialities and requirements in home and community. Furthermore, it was found that such a program was directly dependent upon a similar high standard of practice and resources in the fields of medicine, welfare, recreation, research and parent groups.

Baumgartner¹ stressed that in Illinois, Welfare has an equal, although different, responsibility along with Education. The social worker has the task of working with the parents in the home and with community resources to ensure that the parents will be able to give their child understanding affection, and family life and direction. Without this background of close family support and good personal growth the efforts of the special teacher cannot be received by the child and are not reinforced by home practice. Similarly the courts were seen as needing the help of social workers towards making a better informed decision regarding committal to institutions and, in making available other solutions such as foster homes. Public school education of the Trainable group, it was found, requires close co-operation between many agencies, particularly education and welfare.

The relationship between the public school system and the state residential training school has been most successfully solved in Flint, Michigan, as

1. Loc.Cit.

described by Ingram and Popp.¹ The program for the trainable group was based on an extensive parent training course given by state training school which enabled better understanding of their children, their handling, and use of community resources. The children were then given a full clinic examination which determined whether the child could enter the public school system. The school curriculum included personal care, physical co-ordination, speech and vocabulary training, playing with others and very limited academic activities. Better social acceptability was the goal. Throughout the year the parents were encouraged to take part in school activities and were given additional interpretation in the home. They then took part in the year-end review of their child's progress and nearly all were able to make plans for their child which showed real growth and understanding on the part of the parents.

A unique procedure was worked out in this Michigan scheme² by which the movement of children between Training School and public school system was made very flexible, according to the child's needs. Representatives of the training school took part in clinic evaluation periods so that the parents could be advised and reassured regarding possible placement in the institution. It was found that early admission could be arranged for residential care when required. This was made possible by the other half of the agreement which facilitated return of the child to home and public school on a trial basis as soon as he was ready. This scheme seems to combine understanding of parent-child relationships with exceptional inter-agency co-operation resulting in the best possible use of all facilities in the

1. Ingram, V.M. and Popp, C.E.; "A Public School Program for the Severely Mentally Handicapped Child"; American Journal of Mental Deficiency; Vol. 60 #2, October 1955, p. 285.

2. Ibid. pp. 286-290.

interest of the child.

For those who cannot make use of special provisions in the education system, or for whom no such facilities are available, the State Training School is the usual alternative. These have historically borne the main responsibility for the mentally deficient, and in the United States the large institution has been developed to a high level of specialized structure and function. Although the emphasis continues on training, the general trend is towards a higher proportion of seriously defective custodial patients.¹ The training schools are now rehabilitating the better pupils, while, because of the acute shortage of bed space, they are only admitting the most urgent and severe cases of mental defect. The growth of the public school provisions for the mentally deficient can be expected to bring the situation into equilibrium so that the now rapidly expanding training school facilities can finally catch up to and satisfy the demand for institutional care. However, the primary aim of the training institution continues to be the provision of training and education towards as full and useful a life as the individual's capacities permit.

A good example of a modern training school in the United States is the Southbury Training School, Southbury, Connecticut. Under the leadership of its Superintendent, Ernest N. Roselle, it has become an exceptional institution both in its physical design and in its methods of care and training. In discussing the importance of the physical plan and the need for a great deal of preliminary consultation between architect, engineer, and persons who are

1. Whitney, E.A.; "Current Trends in Institutions for the Mentally Retarded"; American Journal of Mental Deficiency; Vol. 60 #1, July 1955, p. 17.

familiar with the requirements of the mentally deficient, Roselle¹ says:

"Gone forever should be the large custodial plants in our planning of future institutions for children and youth. Let us project for children's institutions home and community aspects which provide something of the inalienable rights of childhood. Let it be a community-like institution of wide lawns and open spaces with attractive and homelike structures in exterior design and planned with the utmost care for the happy, purposeful living of those to whom it is home."²

Roselle then describes the diverse units which make up the institution such as hospital-health centre, classrooms, shops, occupational therapy unit, auditorium, gymnasium, service buildings, staff quarters, garden and farm, but it is the housing arrangement for pupils which is of the greatest interest.³ According to their age and mental ability, the children live in cottages which are like real homes outside and in, giving the effect of a residential district rather than an institution. They are widely spaced with ample room for lawns, play areas, gardens, garage, and place for pets.

For the mildly deficient the outlook is largely towards return to their homes or foster homes after training so that normal household experience is given as closely as possible. There is a housemother and housefather who have their living quarters in the cottage and care for the twenty-four to fifty children. Food is cooked in the cottage kitchen and served in the separate dining room, giving ample opportunity for the pupils to participate. With this comparatively small number of children in each unit much needed personal attention can be given by the houseparents who are in charge of the

1. Roselle, E.N.; "Some Principles and Philosophy in the Planning and Development of Institutional Plants with Particular Reference to Institutions for the Mentally Retarded"; American Journal of Mental Deficiency; Vol. 58 #4, April 1954, p. 598.

2. Loc. cit.

3. Ibid. pp. 607-615

cottage and supervise the additional cottage staff. The plans include sleeping accommodation upstairs, while on the main floor is living room, sunporch, and stury, where various activities can take place without interfering with each other. In the basement are hobby shops and recreation rooms.

The cottages for the Moderately Deficient, care for a somewhat larger group of pupils and are a more simple but comfortable plan. The houseparents live-in here also which has proven to be practical and desirable from the point of view of both pupils and staff.

The severely deficient child is given an infirmary type of housing with about ninety patients to a unit, each carefully designed with regard to personal care and activities. Roselle states emphatically that such cottage accommodation costs considerably less to build on a per capita basis and that costs of maintenance, food, and personnel are no more than that of the large congregate type of institution.¹ He presents a strong case for cottage type schools in terms of both favourable financing and far superior, family-like care and attention.

At Southbury, according to Roselle and Porter,² a group process has been built up whereby all the major treatment disciplines confer regularly to plan and guide the child's progress through the school from his admission to his rehabilitation. This is the Committee on Child Study, Care and Training and includes representatives from Medicine, Psychology, Education and Training, Cottage Life, and Social Service. Following completion of the admission phase the Initial Study of the child begins, about four weeks after

1. Ibid. pp. 612-613.

2. Roselle, E.N. and Porter, E.L.H.; "A Procedure for Study, Care and Training of the Mentally Retarded in a State or Other Residential School"; American Journal of Mental Deficiency; Vol. 60 #1, July 1955, p. 21.

arrival. During this period medical and psychological examinations are made, while in the school or vocational assignment his responses and attitudes are observed. The social worker's findings on the child-family relationship are interpreted to the Cottage Life personnel who closely follow the child's reaction to cottage parents, fellow pupils and group activities. In the meantime the social worker obtains further home and family background information leading up to the admission, including the child's development and behaviour. The parents are given further interpretation regarding the child's condition, and the function of the school in helping him. The parental strengths for helping the child are assessed and the worker continues as a personal link between family and child.

The Committee then meets, studies the reports, and, after full discussion, a training program is formulated which is the agreed finding of all members. The Director of Education and Training is, in the main, responsible and in this school the training plan is carried right through to the cottage parents so that all are working with the child towards the same goals. The Social Service Director may call the committee together when placement is to be considered. The social worker reports on the family resources for the child, and describes the proposed foster home if placement is needed, after which a group decision is reached as to the readiness of the child and the suitability of the plan. Follow-up services are given throughout the State by social workers who represent the two state schools, and two years' successful placement is usually required before discharge.

A special feature of the school is the convertibility of this committee, which may meet under the Director of Psychological Services as a Behaviour Clinic. It can then study and treat serious behaviour and personal adjustment problems. At Southbury then, the child comes to surroundings that have

been specially designed for him, he is given full training to his capacity including treatment of personality difficulties, and is given long term social services on his return to the community.

Rehabilitation to the Community

Perhaps the most direct method of returning the mentally deficient person to the community is through a family care program. By this is meant provision of paid foster care in a home other than the pupil's own, while he continues to remain a responsibility of the institution. A recent survey by Thomas¹ showed that at most only 29 percent of the States have family care programs, although many more were planning such, or were interested.² Family care is a difficult and demanding program containing many pitfalls, such as were described by Benson,³ from his experience in California. The first group of problems, he found, arose from the foster families and from the community.. The social worker's foster home finding was made difficult by the trend to small houses which did not offer the space for an extra person. The foster parents felt that the basic payment of \$70.00 per month was inadequate, although clothing and medical expenses were provided in addition. There were other foster parent difficulties arising from their need to over-protect and "baby" the pupils, and their reaction to the individual's physical handicap, unusual appearance, etc. Some communities made these problems worse by outright hostility to the child and foster family. However, the greatest difficulty seemed to come

1. Thomas, E.; "Family Care"; American Journal of Mental Deficiency; Vol. 60 #3, January 1956, p. 615,

2. Ibid, p. 616.

3. Benson, F.; "Problems Faced by an Institution in Placing Mentally Deficient Patients in Family Care"; American Journal of Mental Deficiency; Vol. 57 #4, April 1953, p. 719.

from the pupil's own parents and relatives who often refused to allow the pupil to leave the institution, or later caused trouble with the foster-parents. A rather unexpected resistance came from within the institution itself where staff were reluctant to lose their best workers and pupils, while hinderances were encountered around the releasing of funds for the operation of the program. Finally, shortage of social workers, and financial resources seriously hampered the program.

The success of the program at the Lapeer Shcool in Michigan appears to be due to the overccoming of just such problems, resulting in the placement of 170 pupils in boarding homes.¹ Funds were available for payment to boarding homes, and for clothing, spending money, and medical care. The additional cost of providing more social workers for foster-home finding, placement, and continued supervision was taken into account. The Lapeer project included a great deal of interpretation by the social workers and close working with the training school staff.² This included individual case discussions with nursing staff, close co-ordination with the business office, and extended even to the switchboard operators who handled the calls from foster homes. This whole area of family placement and community interpretation is a special field of knowledge and skill of the social worker and, with proper resources the social service department made the Lapeer program a success. The family care program resulted in great individual improvement in pupils and in further interest by their relatives. For the school it soon became one of its best methods of interpretation to the community.

1. Op. cit. pp. 616-618

2. Bishop, E.B.; "Family Care; The Institution"; American Journal of Mental Deficiency; Vol. 59 #2, October 1954, pp. 308-318.

The Lapeer program placed severe mental defectives of all ages from 3 to 78 years, which would indicate that age is no barrier to placement.¹ In Massachusetts special placement program for the aged was, in fact, initiated at the famous Waverley institution, when federal funds became available and, for example, involved patients who had been in the school for over fifty years.² The social worker had the heavy role of reshaping individual attitudes and modes of living in preparation for home life. These elderly patients were given intensive and sustained services during the first year of placement following which a careful transfer was made to the social worker from the local Old Age Assistance Bureau. In this, as in the other examples, the effect of family care was to allow others to enter the institution where they could make full use of the special training school facilities, with the expectation that they in turn would eventually be ready for placement in the family care program.

Rehabilitation to the Community

A large group of the mentally deficient return to the community following vocational training in the public schools, or in the state training schools. These schools have developed the mentally deficient pupil in the areas of a social competence, occupational adequacy and academic learning.³ Social competence and academic learning are absolute necessities for job placement. That is, the pupil must have already established proper social patterns of behaviour towards either sex, have self-confidence, and be able to get along with others. He must have some knowledge and skill in elemen-

1. Ibid. p. 308

2. Ekdahl, H.; "The Placement Program for the Aged at Walter E. Fernald State School"; American Journal of Mental Deficiency; Vol. 57 #3, January 1953, pp. 498-503.

3. - - - - "Objectives of the School Program"; Mansfield State Training School, Connecticut, Mimeograph, 1956.

tary oral and written communication, and arithmetic. With these accomplishments, the pupil may be ready to make use of occupational guidance towards successful employment. The Mansfield School in Connecticut is a good example of an institution which offers a thorough program in preparation for employment.¹ The pupil is helped to analyze various jobs with respect to their particular physical and emotional characteristics and requirements. He is then encouraged to measure his own abilities, emotional make-up, experience and interests with the demands made by these jobs. Once a job area is chosen he can proceed to study ways of seeking employment and also the requirements for holding the job. Vocational placement may be done through such agencies as the public school placement services, government services, or by the training school itself.

For those who are not able to produce satisfactorily under conditions of regular employment but who can produce saleable goods under more favourable conditions, the Sheltered Workshop is making its beginning in the United States. Di Michael² defines a sheltered workshop as "a place where any manufacture of handiwork is carried on which is operated for the primary purpose of providing remunerative employment to severely disabled individuals who cannot be readily absorbed in a competitive labour market." He sees it as a place where mentally deficient persons can work indefinitely and also as a training resource or stepping stone to outside employment. The rehabilitation ideal also serves to keep up general morale in the shop and

1. - - - - "Important Basic Background Understandings for Counsellors, Relating to the Mentally Retarded"; Mansfield State Training School, Connecticut. Mimeograph, 1956.

2. Di Michael, SIG.; "Principles and Methods of Establishing a Sheltered Workshop"; Sheltered Workshops; National Association for Retarded Children, New York, 1954, p. 13.

prevents the groups of workers from slipping into a feeling of hopelessness and eventual stagnation, which has happened in some instances. The Sheltered Workshops hold out great hopes for a large number of mentally deficient persons who are not able to compete in the labour market, and the shops are presently being sponsored by parents' organizations. It is to be expected that the workshops would eventually be supported by public funds which would supplement the workers' own contributions from earnings.

To round out the program for the mentally deficient two great areas of need must be fulfilled. A large proportion of those mentally deficient persons who return successfully to the community, still will require some supervision and guidance for the rest of their lives. In the United States there are a few instances of such provisions, for example Minnesota, which has a guardianship program dating back to 1917, and where by law a mentally deficient person may be committed to Guardianship of the Director of Public Institutions.¹ The district social worker is then enabled, and required, to give supervisory services as needed by the individual. The scheme appears to be quite successful but unfortunately such provisions for continued supervision and guardianship are not widespread in the United States.

The second problem referred to is the need for satisfying social and recreational opportunities. The mentally deficient do not easily fit into the usual public recreation facilities, and sometimes not at all. The parents' groups are now looking into this problem and there are some instances of public programs. For example, the Public Welfare Board in

1. Mickelson, Phyllis; "Minnesota's Guardianship Program as a Basis for Community Supervision"; American Journal of Mental Deficiency; Vol. 56 #2, October 1951, p. 313.

Minneapolis undertook a study of such needs within its area and, in co-operation with local social agencies, established a social club for thirty men and women.¹ The leader, a social group worker, taught games and recreation following which some members were enabled to use public facilities on their own. Others held to the group as being their closest social contact and the continued attendance at club meetings remained high, with much enthusiasm being shown by members.

Personnel, Training and Research

Following announcement of the Salk polio vaccine success, Dr. Jonas E. Salk declared that research on mental illness should be the next major effort of science.² It is to be hoped that further interest will also be directed towards the field of mental deficiency. The National Association for Retarded Children has already faced this matter squarely, as Powers points out,³ by proposing in Item 2 of its charter: "To further the advancement of all ameliorative and preventative study, research and therapy in the field of mental retardation", while Item 4 proposes "to further the training and education of personnel."⁴

In April 1955 it was reported⁵ that a Research Director had been chosen

1. McBride, R.; Kaplan, J.; Hall, K.; "Community Planning to Meet Some of the Social Needs of the Mentally Retarded Adult"; American Journal of Mental Deficiency; Vol. 58 #2, October 1953, p. 331.

2. - - - - "News Notes"; American Journal of Mental Deficiency; Vol. 60 #2, October 1955.

3. Powers, G.F.; "Research and the National Association for Retarded Children"; American Journal of Mental Deficiency; Vol. 59 #2, July 1954.

4. Ibid. p. 61.

5. - - - - "Parents"; American Journal of Mental Deficiency; Vol. 59 #4, April 1955.

by the parent's group, Dr. Richard L. Masland. The research project started at the very beginnings by deciding to determine what research is presently being conducted that is related in any way to mental deficiency. Questions were then asked regarding further areas for research, and means of encouraging more scientists into the field.

The National Association for Retarded Children was heartened by its efforts when the Federal Government granted \$750,000. for research in mental deficiency. Another \$750,000. went to related fields which will help with training of professional personnel for work with the mentally deficient.

Summary and Conclusions

Services to the mentally deficient in the United States show a great deal of variation amongst individual states with no one State having achieved a comprehensive program for the mentally deficient. Perhaps Connecticut has come closest to the goal, and this State has been studying its services in order the better to plan for its mentally deficient members. In order to outline these services in America, it has been necessary to describe a number of separate provisions and schemes across the country which best show progressive trends.

The early identification and diagnosis of the mentally deficient child is becoming recognized as being of prime importance, but the facilities are very limited. The presently established mental hygiene and child guidance clinics have not been able to give full service to the mentally deficient and, to fill the gap, parents' groups have in some instances organized special clinics. Only a few states have schemes for the registration of the mentally deficient. Help to parents in caring for their defective children in the home has been successfully given through special programs which offer home

training and parent guidance, day care, and recreation, but again this is limited to a few Eastern States.

The strongest influence towards obtaining better services for the mentally deficient is coming from the young and vigorous parents' organization, the National Association for Retarded Children. The individual groups have undertaken a wide variety of projects which point out the great lacks in public services, and include special schools, play groups, clinics, workshops, recreation, auxiliaries to institutions, and home training programs. The establishment of such services by private endeavour follows the historical pattern of growth of other social programs in the United States, towards eventual public responsibility. The parents' organization has done a great deal to interpret the needs of the mentally deficient to the American public and has followed this with effective demands for further legislation and community action.

Educational facilities in the richer and more populated areas have been established for many years but have included only the educable group in special classes. The needs of the trainable group are presently being met in a few states such as Connecticut and Illinois but generally have been left to the parents' groups. Special secondary school facilities have been well developed, for example, in the city of San Diego, California, but are in no way representative of national facilities. The state institution has undergone considerable evolution in some progressive areas to the point where family-life conditions are being provided by the cottage type institution, complete with parental substitutes.

Some family care programs are in existence but less than a third of the states have even the semblance of such a scheme, and the numbers affected are very small in relation to the total institutional population. The fact

that family care programs have nearly always been operated by the state institutions themselves has had a definite limiting effect on the expansion of such schemes, and on the quality of services given. In the past there have not been sufficient personnel or funds to operate effectively on a large scale. Instead, the family care program has been operated as a local extension of services, of "annex", of the institution rather than as a state-wide scheme. Furthermore, the American community has, in general, been severely lacking in public social services which would form the background for these programs, as is the case in Great Britain. Some good work has been done in vocational guidance and training, but again it is on a local area basis. Sheltered workshops are just in the beginning stages, while social and recreational facilities are left to the voluntary groups. The great need for continued supervision and guardianship has only been recognized for any length of time by the single state of Minnesota.

In conclusion, it has been shown that in the United States there have been contributions made to individual aspects of the knowledge and practice of caring for the mentally deficient. Particular gains have been made in the special area of institutional care and training, with the development of the cottage system and integrated training schemes. The outstanding force for progress is the parents' organization which is making its appeal on a broad basis of public interpretation and legislative and community action. The sample programs which have been described prove that a comprehensive plan can be operated in the United States. The greatest single need at the present is an integration and development of services so that the mentally deficient child can receive early examination and planning, facilities to ensure his full development, and a place in the community where he will receive encouragement and supervision.

CHAPTER 4

SERVICES IN BRITISH COLUMBIA: SOME COMPARISONS, AND IMPLICATIONS FOR FUTURE PLANNING

The Discussion of services to the mentally deficient in British Columbia should gain in perspective and understanding if we first take into account the influence of the historical background, patterns of growth, and geographical features of the Province.¹

British Columbia had its beginnings with the establishment of the colony of Vancouver Island in 1850, the capital being the fur trading post of Victoria. With the influx of gold seekers to the Fraser River, the Colony of British Columbia was formed on the mainland in 1859 and later, in 1866 the two colonies were joined. In those early years there were no provisions for the "insane" in the colonies, the unfortunate persons being placed on board ship for return to the homeland, or, perhaps, to a California Institution.²

In 1871 the colony entered Confederation to become a Province of Canada. A year later the first "provincial asylum" was established in Victoria under the jurisdiction of the Provincial Secretary's Department where the Mental Health Services have since remained. This was followed by the first mental services legislation, "The Insane Asylums Act" 1873 which made no special provision for the mentally deficient.³ Then in 1878, the institution was

1. For further discussion of the historical aspects, the reader is referred to the following sources:

Clark, R.J.; "Care of the Mentally Ill in British Columbia"; Unpublished M.S.W. Thesis, School of Social Work, University of British Columbia, 1947.

- - - - "Mental Health Services, Annual Report"; Province of British Columbia, Victoria, 1953.

2. Ibid. p. 15.

3. Loc. cit.

moved to the mainland at New Westminster where a new building had been completed. This is the site presently occupied by the Woodlands School, which is the provincial training school and institution for the mentally defective. In comparison to these pioneer efforts for the insane which lacked any separate provisions for the mentally deficient, it will be remembered that several American states, and Great Britain, had been training the mentally deficient in separate institutions for over twenty years, while such a school had been in operation at Orillia, Ontario, since 1876.¹

At the turn of the century the focus of attention for mental health services was shifted to the Coquitlam site where the well-known Colony Farm was soon in operation, to be followed by the gradual development of nearby Essondale as the centre of mental health services for the province. For the mentally deficient, the first three decades of the century brought few services beyond segregation within the hospitals. However, their special needs did not go entirely unrecognized and Clark states that the Mental Hygiene Survey of 1919 recommended the establishment of facilities for diagnosis, training, and special classes for this group.² Successive Medical Superintendents stressed these needs, which were fully recognized in the findings of the Royal Commission on Mental Hygiene, 1925. These are reported by Clark as emphasizing the urgency and importance of provisions for the mentally deficient, especially in the educational field.³ As a result, further building took place at Essondale and patients were transferred from New Westminster. Finally, the old New Westminster institution was renovated and in 1931 became a separate institution for mental defectives. However,

1. - - - - "Mental Health Services in Canada," Memorandum #6, Department of National Health and Welfare, Ottawa, 1954, p. 9.

2. Op. cit. Clark, p. 65

3. Ibid. p. 84

it was not until 1945 that the academic school was built and staffed, and training begun.

From this historical outline it can be seen that British Columbia does not have an old tradition of services to the mentally deficient nor a long established system of schools and facilities, upon which to build. The second half of the last century saw the rapid expansion of the training school system in Britain and the Eastern American States, during which time British Columbia was in a state of evolution from a band of traders and gold-seekers to a more settled and permanent population. Thus, by the time that the needs of the mentally deficient were becoming apparent in the province, the enlightened era of the training ideal had given way to the period of segregation from society by means of institutional care. It would appear that this historical factor might have been largely responsible for the lack of services to the mentally deficient in British Columbia for so many years. This is supported by the fact that services to the mentally ill in the province have shown no such lag but generally kept pace with other areas, maintained a good reputation, and at times have been outstanding. A large factor in the conversion of the New Westminster institution to the care of the mental defectives would seem to have been the overcrowding they caused in the mental hospital and the advent of treatment procedures for the mentally ill which required better classification and segregation of patients. In any case, the first fifteen years of the training School were characterized by economic depression and war so that it was not until 1945, with the building of the new academic school facilities, that the mentally deficient in British Columbia began to receive some of the opportunities and services to which they had long been entitled. It is to be hoped that the fairly

recent awakening of public interest in the mentally deficient can be maintained and strengthened so as to guarantee continued progress in the understanding and care of the mentally deficient.

The physical aspects and population characteristics of British Columbia form a unique pattern which has important implications for the operation of any province-wide program for the mentally deficient. The terrain is predominantly mountainous and the ratio of urban population to rural is one of the highest in Canada, over 68 percent being urban in 1951, as revealed by the ninth Census of Canada.¹ Furthermore, a large proportion of the population resides in a relatively small area, the Lower Mainland and Vancouver Island, leaving for the remainder of the province a population density of just under one person per square mile, one of the lowest in Canada. To illustrate further, the population of British Columbia in 1951 was 1,165,210, while that of the Vancouver Metropolitan Area was 530,728, which means that nearly half of the citizens of British Columbia live in or around the City of Vancouver.² There is another large urban concentration at the southern tip of Vancouver Island, and other centres in the mountain valleys of South Eastern British Columbia, and the Cariboo. The administration is thus faced on the one hand, with the provision of adequate services to one of the largest cities in Canada and, on the other, with responsibility for the rights of the mentally deficient persons who may be residing in some isolated location in the interior of the Province. There are problems involved in bringing the service to the individual, as well as for the family in maintaining contact with the mentally deficient member, who may be in an insti-

1. - - - - "Vital Statistics Report for 1953", Province of British Columbia, Victoria, 1955.

2. - - - - "the Canada Year Book 1955", Dominion Bureau of Statistics, Ottawa, 1955. pp. 135 and 139.

tution several days' travel away. In addition to difficulties regarding distance and communication, there are great differences in the resources available to the individual, according to his place of residence. In the urban centre the pupil may have at his disposal special diagnostic, educational, occupational, and social services, which may be totally absent in remote rural districts. It is this inequality of opportunity which will require considerable planning and action before it can be overcome in British Columbia.

In discussing the program for the mentally deficient in British Columbia it is essential to know as accurately as possible how many persons there are in the province who are in need of the various services. Roselle described the findings of his Connecticut survey of 1954 stating that the problem was not essentially different in any state either as to quality or proportionate quantities.¹ This survey recorded its findings on the basis of the number per 100,000 of the population, from which the corresponding figures can be obtained for a given population. Roselle stated that the proportion of each group of the mentally deficient in the general population of the deficient was as follows: 60 to 65 percent are mildly deficient, somewhat less than 30 percent are moderately deficient, and 9 to 10 per cent are severely deficient. It was felt that the range of figures given, which centred around 1 percent of the population, indicated possible variations and would be a help to planning.²

Table I, page 84, gives the estimated numbers of the mentally deficient by groups, in British Columbia, as extrapolated from the Connecticut figures

1. Roselle, E.M.; "New Horizons for the Mentally Retarded When a State Looks at the Problem as a Whole"; Washington State Convention, National Association for Retarded Children, Bellingham, Mimeograph, 1954, p. 9.

2. Ibid. p. 12

Table I. The Mentally Deficient in the Total Population of British Columbia, 1955.

Group of Mental Deficiency	Number per 100,000 Total Population. ¹	Estimated Number in British Columbia. ²
Mild	500 - 700	6,500 - 9,000
Moderate	225 - 325	3,000 - 4,250
Severe	75 - 110	1,000 - 1,500
Totals	800 - 1,135	10,500 - 14,750

Source: 1. Connecticut Survey, 1954, as reported by Roselle.
 2. Based on British Columbia population estimate 1,300,000 for 1955, an approximation for purposes of this essay.
 - - - "The Canada Year Book 1955, Dominion Bureau of Statistics, Ottawa, 1955, p. 135.

Table 2. Mentally Deficient Children in the School-Age Population, British Columbia, 1955.

(Ages 5 - 7 years inclusive)

Group of Mental Deficiency	Number per 100,000 School-age Population. ¹	Estimated Number in British Columbia. ²
Mild	1,500 - 2,000	4,100 - 5,450
Moderate	300 - 450	800 - 1,250
Severe	100 - 150	270 - 400
Totals	1,900 - 2,600	5,170 - 7,100

Source: 1. Op cit.
 2. Based on School Age population of 272,000 an extrapolation from "Vital Statistics Report", 1953, Province of British Columbia, Victoria, 1955, p. 14.

for the general population. The total population of British Columbia for 1955 is estimated to have been approximately 1,300,000, for the purposes of this essay.¹

Table 2, page 84, gives the estimated number of mentally deficient children in the school age population, ages five to seventeen (inclusive) in British Columbia, again from the Connecticut findings. This school age population for British Columbia is estimated at 272,000.² The incidence for the school age population was found to range between about 2 to 2.5 percent., with the group proportions as follows: slightly less than 80 percent are mildly deficient, somewhat more than 15 per cent are moderately deficient, and between 5 and 6 per cent are severely deficient.³ With these proportions in mind for the general and the school populations we can proceed to examine the services being given in the province.

Identification of the Mentally Deficient in British Columbia

There is no co-ordinated scheme in the province to ensure the identification, diagnosis, and guidance of the mentally deficient. In the absence of this it is necessary to discuss the functions of some representative agencies who are involved in providing this service. In Vancouver a large proportion of hospital facilities are concentrated in one massive institution, the Vancouver General Hospital, within which, the Child Health Centre is a small hospital in itself, containing over 150 beds.⁴ Children are brought in from long distances to make use of the special facilities available and

1. - - - - The Canada Year Book 1955, Dominion Bureau of Statistics, Ottawa, 1955, p. 135.

2. By extrapolation from:
"Vital Statistics Report, 1953"; Province of British Columbia, Victoria, 1955, p. 14.

3. Op. cit., Roselle, p. 12

4. Interview with Mr. K. Weaver, Director of Social Service Department, Vancouver General Hospital, and staff.

amongst the patients who have been admitted for observation and diagnosis are young mentally deficient children, who may sometimes occupy half a dozen beds in the Centre. To examine these children there is, however, not one psychologist or psychiatrist on the staff of the hospital and both have to be brought in for individual consultation. For psychological testing and evaluation the Centre has to rely on the services of visiting professionals from the Metropolitan Health Committee, the Provincial Child Guidance Clinics and occasionally private agencies. Thus, contrary to what might be expected, there is no established diagnostic clinical team at Vancouver General Hospital, the largest hospital in the Province.

The social service department of the hospital is particularly concerned with resources for mentally defective babies who no longer require medical treatment but who cannot be returned home for reasons such as unsuitable parents and home conditions, the mother being unmarried, ill, etc. There is a very long waiting list for admission to the provincial institution, the Woodlands School, and, once application is made hospital insurance ceases. The parents then become responsible for payments of over sixteen dollars per day. The Children's Aid Societies do not feel that it is their function to accept these children while the hospital social service is certainly not a child placing agency, and a serious state of impasse results. It has been found that although their numbers are comparatively small, the mentally deficient create exceedingly difficult problems for the social worker in this setting. Along with the resulting lack of custodial facilities there have been many instances of marriages breaking at this time of strain. For some of the older patients, including for example, an unmarried mother, the protracted waiting period before admission to Woodlands School has been dis-

astrous, with a repetition or worsening of their problems.

The Vancouver General Hospital provides medical care for the mentally deficient patient and social services to the patient in the hospital and to his family. For diagnosis and planning the services of other diagnostic agencies are used, particularly the Provincial Child Guidance Clinic.

The Provincial Child Guidance Clinics provide the main diagnostic services in British Columbia. Established in 1932 with personnel from the Provincial Mental Hospital, the clinics have had great demands placed on them for services and have gradually expanded. The main clinic has recently moved into a modern new building in Burnaby where two clinical teams are available, and from which the travelling team operates in taking services to other parts of the province. Already there is need for a second Mainland travelling team, and the obtaining of staff for it is expected to be a problem.¹ The second clinic is in Victoria where a team serves that city and travels Vancouver Island. The total personnel include four psychiatrists (one is in training), nineteen social workers, ten psychologists, four public health nurses, and a speech therapist. These teams must not only serve the province as a whole but also give regular scheduled clinics at such institutions as The Children's Hospital, The Health Centre for Children as referred to above, and Jericho Hill School for deaf and blind.² One result of these demands has been the curtailment, or delay, in being able to give continuing casework services beyond the diagnostic study period. If other social agencies were better equipped to give preventative and treatment services, the clinics

1. - - - - Mental Health Services Annual Report 1955; Province of British Columbia, Victoria, 1955, p. (201)

2. Ibid. p. (199)

could function better.¹ Some relief is afforded by the diagnostic clinical services given by the Metropolitan Health Committee to the Vancouver Schools, and by a new Burnaby Mental Health Centre.

The Child Guidance Clinics, in the course of examining children regarding various problems and disorders, saw 876 new cases, of which 123, or 14 percent, were classified as being mentally deficient. The proportion of Intelligence Quotients below seventy was somewhat higher at 15.5 percent.² This sizeable group includes individual referrals, usually through social and health agencies. The clinic already is the screening agency for St. Christopher's School,³ for mentally defective boys, and is now receiving requests to do group screening for many new parent-operated schools. The increasing demands for services to the mentally deficient are being felt by these already overtaxed clinics and a satisfactory solution will soon be required.

Diagnostic services for the mentally deficient will have to be provided on a large scale, particularly with the rapid growth of local educational facilities and home care, and responsibility would appear to lie with either the Child Guidance Clinics or the Woodlands School. At present the Clinic is not an exclusive screening agency for Woodlands School although it does a good deal of this kind of work. With regard to future policy, the Provincial Child Guidance Clinic could possibly be considered for the role of primary screening of the mentally deficient, but only under certain conditions.⁴ The initial screening could be done by the clinic, and its travel-

1. Ibid. p. 206 and 208

2. Ibid. p. 205

3. Interview with the Director, Dr. U. P. Byrne, and Mr. D. Ricketts, Supervisor, Social Service Department, Child Guidance Clinic.

4. St. Christopher's School will be discussed further in the next section.

ling team, with referral then being made to a new clinic at the Woodlands School where specialized diagnostic and planning services would be available. The assumption of this new role of actively seeking out the mentally deficient would require considerable extension of personnel and facilities for the Child Guidance Clinics. It would appear, then, that a new clinic at Woodlands School is the first requisite in an extension of services, to be followed by allocation of the work in preliminary screening.

In British Columbia there is no separate registration of the mentally deficient although this is done in part by the Crippled Children's Registry in Vancouver. This agency is supported by Federal Health Grants, is supervised by the provincial Division of Vital Statistics and receives medical direction from an Advisory Panel made up of some sixteen specialists from medicine and psychiatry, representing private and governmental practice. Other advisors come from statistics, nursing, and social work.¹

The crippled child is defined as "one who suffers from a handicap sufficiently severe that he or she will be at a disadvantage in acquiring an education or earning a livelihood."² By the end of 1955 more than 7,000 cases had been registered but of these only some 500 were mentally deficient and many had additional physical disabilities.³ At present registration is done voluntarily by medical practitioners, many public health and welfare agencies, including particularly the Child Guidance Clinics, various institutions, and by notations on birth registrations. The registry advises and directs patients to the best medical care and interests itself in the whole problem of rehabilitation including the socio-economic aspects. It acts as a co-ordinator for various agencies and resources, and from statistics

1. - - - Crippled Children's Registry, Third Annual Report, 1954, Mimeograph, Vancouver, pp. 1-3; and Mimeographed Information Sheets, February 7, 1956.

2. Loc. cit.

3. Loc. cit.

compiled can make recommendations as to areas of care which are not being fulfilled.

The registry for handicapped children has available the full resources of the Division of Vital Statistics, Department of Health and Welfare, and already enjoys the participation and co-operation of the fields of health and welfare. Therefore, it might well be expanded to care for a more complete registration of the mentally deficient.

The success of any program for the identification and diagnosis of the mentally deficient appears to hinge on legislative provisions which require that some agency seek out these individuals, and present them for examination at clinics which must be available. This is done in Britain through the Education and Mental Deficiency Acts with the co-operation of school and health authorities. If, for example, the school authorities of British Columbia were required to register all mentally deficient children we should have taken a firm step towards granting them their rightful opportunities. A new clinic at Woodlands School would form the centre of diagnostic services, and travelling clinics would take services to the more remote parts of the province. This might be done from Woodlands or from the Child Guidance Clinic, and in any case continued close co-operation would be required. The Crippled (Handicapped) Children's registry would have to be prepared for its additional function. It might be noted that none of these new services is particularly expensive to put into effect, but the requirements include trained personnel who are not easily obtained.

Home Care and Family Services

It has only been recently, if at all, that the parent who decided to care for his child at home received any encouragement from his fellow cit-

izens in British Columbia. The families were not helped with educating the child in the home, they were given no assurances from the state that supervision or guardianship would continue throughout their child's lifetime, nor were there financial provisions and community social resources. In short, there was no one to whom the parent could turn for help and encouragement.

Social agencies such as the Family Services Association of Vancouver offer intensive casework services on a selective basis only. The number of cases active in which mental deficiency is involved has been small, but they have been characteristically of a long term nature.¹ Parents have used the agency for help in methods of handling their defective child as well as understanding their own feelings towards him. An occasional parent arrives at the agency, whose defective child is now grown up, and for whom the time for training and learning has long since passed by. The agency is privately supported and has limited resources, requiring a careful selection of cases, and leaving some facilities for new enterprises and projects. Thus the agency cannot take responsibility for a whole program as such, but can accept referrals in which there is a constellation of problems of a family nature, one of which might be mental deficiency.

The parents of the mentally deficient in the province are now banding together very quickly, with mounting enthusiasm. On March 24th, 1955, the Association for Retarded Children of British Columbia was incorporated and the first annual meeting was held on May 13th in Vancouver.¹ By the end of the year there were nine chapters with a membership of 1,750. The Association is the central organization to which the local units belong. It aims

1. Interview with Miss B. Finlayson, Assistant Director, Family Services Association.

2. Interview with Dr. H. G. Dunn, Deputy Medical Executive Director; Association for Retarded Children of British Columbia; and mimeographed material he supplied, including minutes of meetings, and newsletters, 1956.

to promote the education, training, development and welfare of all mentally deficient children whether at home, attending school, or in institutions. Its objects also include encouragement of further local units, and encouragement of research, good public understanding, personnel training, and legislation in this field. The Association is very active in this role of co-ordination and enabling, while all individual members belong to local units where the actual projects are undertaken.

The local units have first been interested in forming special classes for those who are not served by the public school, mainly the trainable group. By the end of 1955 there were nine day schools operated by the local chapters across the province. One group has formed an Auxiliary to the Woodlands School whose members visit the pupils, perform a number of much needed personal services for pupil and family and offer social outings. The strong Kootenay Society for Handicapped Children is planning to build a home to accommodate about fifty children. It will function as a day school, boarding school, and parental home for children in the event of family crisis. This will alleviate a great deal of hardship for families in that Interior District and provide much needed educational facilities for its scattered population.

The St. Christopher's School Society in North Vancouver is also a member of the Association.¹ This Society had its origins in 1928 with the devoted work of Nurse Graham, who opened a clinic, and later, the school for mentally defective boys. It is a residential school with accommodation for twenty boys and offers a homelike atmosphere, basic training and activities, and

1. St. Christopher's School Society is a non-profit organization, whose Board of Directors receive no remuneration. It has solicited funds for capital expenses from private individuals and corporations, and its fees are based on the operating requirements of the school.

individual attention to special training. This school has carried on alone in its type of service for nearly thirty years and should now benefit from the support of the large Associations.

The growth of the movement may be illustrated by the fact that in January 1956 at least seven new chapters were being formed, ranging from Burnaby in the Greater Vancouver Area, to Dawson Creek in the extreme North East. Organization was proceeding on a national scale also with a meeting being held in January, 1956 at Winnipeg, of provincial representatives, to found a Canadian Association for Retarded Children. This group will have as members the provincial organizations and will encourage services for the mentally deficient from the national level, and again be a co-ordinating and study group.

The appearance of this strong and active Association for Retarded Children is the outstanding feature of the field of mental deficiency in British Columbia today. Their first major Provincial goal has already been achieved through their own efforts with the passage of legislation for the financial support of children in their special schools, which will be discussed later. With much of the financial burden of education and training removed, the groups can be expected to turn their attention to improving facilities.

In addition to legislative requirements for supervision, guardianship, and financial aid to families such as have been so successful in Britain, there is also the need for services to the home. There are many children and families who need the help of a special visiting teacher to direct the training and education. An even larger number of families need the opportunity to discuss their problems arising from the deficient child and receive the help in planning which the social worker can provide. The Connec-

ticut program for family care as previously described might well be adapted to at least the more populous areas of the province. The many facilities which offer relief to parents and happiness to the child should be established as soon as possible, in order to strengthen and encourage home care. These include occupational centres, recreational facilities, summer camps and day care centres.

Education, Training and Custody

The education of the mentally deficient in British Columbia is still in the "permissive" stage so that each school board may decide whether or not to provide for this group. The result is a wide variation across the province in accordance with population density and financial resources. Dr. Dunn reported that at the end of 1955 there were sixty-four special classes spread over twenty centres in British Columbia.¹ A brief discussion of the Vancouver School provisions will serve to show what progress has been made in a large city.

The Vancouver School Board,² has endeavoured to give opportunities to every educable child, approximately down to I.Q. 50, and has located the special classes in the regular schools, since it is the School Board's philosophy that the mentally deficient should take part in the usual activities wherever possible, such as physical education, social activities, and student affairs. There were 565 of these pupils registered in the school year 1955-56. With a total school population of 51,648, the mentally deficient made up over one percent of the enrolled school population, which,

1. Loc. cit.
 2. Interviews with Dr. R. F. Sharp, Superintendent of Schools, Vancouver, and Dr. S. A. Miller, Director, Department of Research and Special Services.

it was considered, indicated a good coverage.¹

The Vancouver schools have diagnostic clinical services readily available in the facilities of the Metropolitan Health Committee. The principal of the school reports suspected cases of mental deficiency to this clinic for testing and evaluation, following which, the child may be placed in a special class. There are three types of classes available for this group, Junior Special, Senior Special, and Junior High Special, according to the child's age and development. The child is encouraged to continue right through Junior High School in special classes and there were 165 such pupils in the secondary schools. These classes are located where there are good manual arts facilities and the courses are heavy in these subjects, which include woodwork, metal work, and electric wiring for the boys, and sewing and home economics for the girls.

In addition to special classes for the mentally deficient, there are another 500 students receiving special types of schooling such as sight saving classes, educational difficulties, hospital and home instruction. The fact that there are visiting teachers for the physically ill in the home, should give encouragement to those who seek such services for the mentally deficient.

Education for the mentally deficient became more complete with the passing of Bill No. 68, "An Act to Amend the Public Schools Act," at the spring session of the British Columbia Legislature, 1956.² This progressive measure made financial provision for the education of the trainable group of the mentally deficient. The Board of School Trustees of a District

1. Loc. cit.

2. Loc. cit.

was empowered to make payment to a chapter of the Association for Retarded Children of British Columbia for the education of authorized pupils. The amount payable was not to exceed the average cost of educating the normal child in the province, which was nearly two hundred and fifty dollars for the school year, 1953-54.¹ The regulations had not yet been promulgated. The system appeared to be similar to that in Ontario, except that the latter made a straight payment of twenty-five dollars for each month that the class was in operation.² The Vancouver schools, will carry out this permissive legislation, although it is expected that an administrative committee of School and Association members will first be required.³

It would appear that the next step in education would be to make attendance for the educable compulsory, as is done in Great Britain and some American States. Facilities for the trainable should be made available through the province, and attention paid to the need for help with home training.

The centre for residential care, training, education, socialization and rehabilitation, is the Woodlands School at New Westminster, as noted earlier in the historical outline. The name of this institution was changed to the Woodlands School in 1950, and in 1953 the "Schools for Mental Defective Act" was passed, establishing it as a specialist unit for the mentally deficient and making all admissions direct to the school.⁴ The School offers care, supervision and protection for the mentally deficient who require such services. It then proceeds to treat and educate the pupil to the maximum of

1. - - - - "Public Schools", 83rd. Annual Report; Province of British Columbia, Victoria, 1955.

2. - - - - "Assistance in Payment of Cost of Education of Retarded Children"; Ontario Regulations 114/53, June 1953.

3. Op. cit. Dr. R. F. Sharp.

4. - - - - Mental Health Services Annual Report 1953; Province of British Columbia; Victoria, 1953, p. 18.

his capacity. There are many professional disciplines which work together towards rehabilitation of the pupil, or improvement of his adjustment to care, possibly in a family outside the hospital. More recently the treatment services have been closely co-ordinated in rehabilitation clinics at which all those concerned with the pupil have an opportunity of discussing the case and taking part in the decision which directs his program towards rehabilitative goals. This group process of treatment is becoming successful as well in the area of staff development and interpretation, and may be compared favourably with the Southbury system which has already been described.

The Social Service Department although relatively young and few in numbers has many responsibilities throughout the treatment and training process. The social worker must first be ready to help the parent in coming to a decision regarding application for admission by careful orientation to the School and interpretation of the School's function in relation to the parent's situation. The child and parent are given help on admission in becoming accustomed to the institution and to the separation. The worker brings social history information as part of the planning process for the child and may offer continued services to the individual in order to help him reach a better level of emotional maturity, and socialization. As the time for rehabilitation approaches the worker becomes very active in the preparation of the pupil and his family for return to the community. The pupil must be helped to find the kind of employment which would be suitable for him and given continued supervision, as well as services to the family and employer during the probation period. The social service experience in rehabilitation of pupils has disclosed flaws in the training program and adjustments are being made. Resources for rehabilitation have been seriously lacking and these gaps in the program are brought to the attention of the administration.

The future role of Woodlands School is expected to be the care of the trainable, and lower groups, those in the Moderate and Severe groups of mental deficiency.¹ In addition will be the important function of treating those with emotional problems in addition to mental deficiency. The schools are expected to care for the educable group in the community, although it is realized that this may require many years of development. At present the Woodlands School population is over 1,200, and, although a new 300 bed unit is nearing completion, the waiting list already surpasses this figure for new accommodation.² It had been hoped that no new institutional facilities would have to be built but unfortunately this optimism appears to be based too heavily on the expected effects of the new educational measures. Increased rehabilitation resources will be required for the return of more patients to the community while better community facilities are required in order to encourage more families to care for their child at home. The establishment of a diagnostic and planning clinic at Woodlands may increase the number of the mentally deficient who are identified but at the same time it can offer alternative plans to the parents and admit only those who can best make use of the School, or who require custodial care. /

It was noted earlier that the modern concepts of child care and human development called for a cottage type of institution in which the system of house parents and small groups encouraged normal personality growth in a quasi-family environment. These principles, which were laid down years ago after the very successful American Experience, could be put into effect with all their advantages to the child, for a smaller per capita cost than the

1. Interview with Dr. C. E. Benwell, Medical Superintendent, The Woodlands School, New Westminster.

2. Loc. cit.

outmoded congregate type of building.¹ A recent example of an institution designed specially for the care and training of the mentally deficient, is the new Saskatchewan Training School at Moose Jaw.² This school can be a source of pride to those who made use of available experts in this field of specialized architecture. Unfortunately, the new three hundred bed unit at Woodlands, a many-storied concrete structure, violates these principles and the rights of the children who will occupy it. It will be left to an already over-taxed nursing staff to bring in some kind of family atmosphere.

Rehabilitation to the Community

A basic objective of the new program of training and education at The Woodlands School is the socialization of the pupil, which is the ability to live with others in such a manner that the can become an accepted member of the family and of the community. A system of foster homes is now needed for those pupils who have been successful in their training at Woodlands and cannot return to their homes.

Because there is no family care program for the mentally deficient in operation in the province, agencies such as the Children's Aid Society of Vancouver receive many requests for services to this group. The problems and views of this Agency in the area of foster home care of the mentally

1. Roselle, E.N., "Some Principles and Philosophy in the Planning and Development of Institutional Plants, etc."; American Journal of Mental Deficiency; Vol. 58 #4, April 1954, pp. 612-13,623.

2. Black, H.K.; "Saskatchewan Training School, Moose Jaw"; Mental Hospitals; Vol. 6 #11, Washington, D.C.; November 1955, pp. 21-28.

The Moose Jaw institution consists of multiple, single-storied buildings of 50 pupil capacity, with all joined to central administration, dining and heating facilities. Although it is a great advance over large hospital type construction, it is really a congregate type of institution. It therefore falls short of the goal of family-like cottage living under the supervision, not of nurses, but of cottage parents.

deficient will therefore be briefly reviewed.¹ The critical problem which the society faces is the care of the severely deficient child awaiting admission to Woodlands School, and is caused by the serious shortage of accommodation at that institution. Referrals are often of an emergency nature when, for example, parents become ill, or babies have to be removed from acute hospitals, as previously discussed. It is very difficult to find accepting foster parents for this severely defective group and the special needs of these individuals are more than a foster home can offer. Their problems take a large proportion of the social worker's time and attention. The Society has been advocating establishment of special facilities for the emergency placement of the grossly mentally deficient child, while the Medical Advisory Committee of the Association for Retarded Children of British Columbia have also made representations.

The second problem is the long range planning for the boarding-out care of the mentally deficient child. At the present time the Children's Aid Society is caring for a number of children described as seriously mentally retarded. Special boarding rates are being paid but again the group does not fit in well with the general program. From its experiences with the individuals from this group, the Children's Aid Society questions the benefit of foster home placement for the child himself. The Children's Aid Society has come to the belief that a family care program for the mentally deficient is principally the responsibility of the Mental Health Services. The Society, however, continues to be willing to take part in further discussions around this and related problems.

1. Interview with Miss D. Coombe, Executive Director, Children's Aid Society.

The Administration of Mental Health Services, for its part, recognizes the need for a family care program, and plans for implementation are at an advanced stage.¹ The Schools for Mental Defectives Act, 1953,² already makes provision for such a plan, subject to the drawing up of Regulations, which is presently being done.

The operation of a family care program from The Woodlands School will place additional heavy responsibilities on its Social Service Department. The social worker will be required to carry out home-finding and evaluation duties with much community interpretation of the new program. The worker will be active in the selection of pupils, and their preparation for foster home living. Then will come actual placement and continued follow-up services to pupil and foster parent. These will include help with the pupil's adjustment to the new situation, financial matters, and use of community resources including occupational guidance where applicable. Through this program many pupils could be placed who are incapable of supporting themselves, while the home can also be used as a stepping stone for some towards partial or complete economic self sufficiency. Such a program, as can be seen, makes heavy demands on the services of the social worker and appropriate additions of personnel to the Social Service Department are imperative.

An additional financial resource may be the provisions of the Federal Disabled Persons Act, 1955, which pays pensions to the totally and permanently disabled, who are over eighteen years of age and are not patients in an institution. The medical requirements include, for the mentally deficient, the need for constant care or supervision, and it is suggested that their I.Q.'s

1. Interview with Dr. C. E. Benwell, Medical Superintendent, Woodlands School.

2. - - - - "Schools for Mental Defectives Act"; 1953, Chapter 26, Section 17 (2), Province of British Columbia, Victoria, 1953.

would seldom exceed sixty-nine.¹ It would appear that these pensions, with the Provincial Bonus according to eligibility, would be mainly applicable to those of the mentally deficient who were cared for at home, away from the jurisdiction of the institution. The pensions are becoming widely used for this group.

The vocational rehabilitation of the patient is a much needed service both for the child in the home and the one who would be able, possibly, to leave the institution and earn his living. At present such services are in a rudimentary stage in British Columbia and, have not yet become a function of the Provincial Co-ordinator for Rehabilitation. It was noted earlier that the special classes and residential schools offer some occupational training but that much more is yet to be done. However, for those who are ready to work there are the job placing services of the National Employment Service, Special Placements Section. In Vancouver this section has found that most referrals of the mentally deficient were made by Children's Agencies, and the School Counsellors for the special class pupils.² At the end of March, 1956 the mentally deficient men made up 14 of the total of 151 men who were listed as unplaced or about 10 percent, while the women defectives accounted for about 5 percent of women who were not placed. The Section has no clinic facilities and occasionally has used the Youth Counselling Service for evaluation of an applicant. In addition to this lack of available diagnostic services, the Special Placements Section finds that a higher standard of basic training in preparation for employment is a prerequisite to successful placement. The mentally deficient should receive training which is geared to

1. Interview with Mr. E. W. Berry, Chairman, Disabled Persons Act, Vancouver.

2. Interview with Mr. H. McKay, Supervisor, Special Placements Section, National Employment Service, Vancouver.

the requirements of local industry.

The Special Placements Section at Vancouver has found that the mentally deficient generally can carry out the job satisfactorily once the initial employer-resistance is overcome and the man is hired. Types of employment include kitchen help, janitor work, and domestic work. The National Employment Service considers the placement of the mentally deficient to be one of its functions but officials point out that this agency also suffers from personnel shortages. Because of this, the placement officer is restricted in the number of personal interviews with both applicant and employer that can be done, yet these are most important in the placement of the mentally deficient.

At the present time there is no full-scale sheltered workshop in operation for those who cannot compete on the open labour market. The need is being made known by the Parents' Association, whose medical advisors recently went on record as strongly supporting such a project. There is one part-time experimental project in operation by the New Westminster Association, with young adult pupils from the Woodlands School. Similarly, there are no facilities for social and recreational activities for the mentally deficient, except what is being provided by the Associations.

When compared to countries which are more advanced in this area, the facilities for rehabilitation of the mentally deficient in British Columbia are in the barest beginning stages. The family care program projected for Woodlands School is a step in the right direction but would have to be greatly expanded in services before it could compare, for example, with the nationwide British scheme for care of mental defectives in their own homes, or foster homes. Vocational training and placement have reached a high level of performance in the United States both in residential schools and in the

public school system and could well be applied to the British Columbia scene. Similar gaps are evident in the provision of sheltered workshops or the British equivalents of Occupational Centres and Industrial centres, and also in social activities for the mentally deficient.

One of the most striking omissions in the British Columbia scene is Supervision or Guardianship provisions, especially for those who are away from their own homes. Supervision carries with it the responsibility for continued interest in and protection for the individual throughout his life. Around this guarantee of continued responsibility the whole framework of services to the mentally deficient should be built, with each section designed towards helping the individual to function at his best throughout his life.

Personnel Training and Research

In nearly every section of the British Columbia program shortages of trained personnel have been noted as a limiting factor in doing the job. This has been true for such skilled personnel as nurses, teachers, psychologists, social workers, vocational counsellors, occupational therapists, and physio-therapists, and speech and hearing therapists. This serious difficulty in training and maintaining the required special personnel has been prevalent in all the programs studied. Probably financial aid for the long training courses, and generally better opportunities and salaries, would help the situation. It still remains, however, as a field which requires considerable research before the solutions will be found. In British Columbia some medical research is being done with the help of Federal Health Grants and this will aid in the continued search for the prevention and the better care of mental deficiency.

A Co-ordinated Program

The needs of the mentally deficient person change in their characteristics as he progresses through life. So, similarly, the kinds of services available must be of wide variety and focussed to meet these needs. In order to accomplish this, all the many complex services must be linked together in one overall program to ensure common goals, maximum efficiency, and a truly continuing service to the individual. Perhaps this could best be done by a representative Board, bringing together Mental Health Services, Education, and Parents Associations for broad planning of services and policy. The actual administration could be through the Woodlands School, which would be giving many of the services.

A program which is inclusive of the needs of the mentally deficient would begin with diagnostic services which would be made available to all in the province. This requires a new Clinic at Woodlands School and travelling clinics for more sparsely populated sections of the province. An agency such as the schools would have the duty by law of seeking out the mentally deficient and registering them with the Crippled (Handicapped) Children's Registry. Parents would be helped to understand their child's condition and there would be resources at hand which would enable realistic planning.

Visiting teachers and social workers would, wherever possible, help the parent in training the child at home, and in meeting the many problems of the child, and those of a family nature. Home care would need to be strengthened by financial provisions, supervision where needed, and health services. Relief for the family and child should be provided by day centres and summer camps.

The new Education Act would be extended to make provision for classes for the educable and the trainable children equally across the province, with attendance of the educable being required by law unless otherwise arranged with the school board as with normal children. The classes would extend into high school and provide vocational training and guidance, and preparation for employment. The Woodlands School would expand its facilities for the treatment of those mentally deficient children who were emotionally disturbed, and improve its vocational training and employment preparation.

Rehabilitation would occupy a more important place in a comprehensive program. A Family Care program would be offered throughout most of the province with adequate financial arrangements and full Social Services to the home and pupil, centred in the Mental Health Services at Woodlands. The pupil who was ready for employment would have job-finding and counselling services readily available at an expanded National Employment Service. Sheltered Workshops would be established with government support where others of the mentally deficient could partially earn their living or obtain further confidence and training. In addition to his basic needs for family ties and a worthwhile occupation, there would be facilities for recreation, social clubs, camps, etc., where the mentally deficient could share enjoyable experiences with others of a similar level of interests and abilities.

The future prospects for his group would be enhanced by active programs of personnel training and research into problems of a medical nature and into the social aspects of the program as well.

The individual would be assured of supervision continuing throughout his lifetime with services available for any particular phase. The interests of the group as a whole would be safeguarded by a continuation of the strong

leadership and faithful services of the parents, acting together through their local groups.

The implications of such a scheme are particularly great for the profession of Social Work. Many highly skilled and strongly motivated workers will be required to carry heavy portions of the programs from the early diagnostic process, through training, personal and family services, rehabilitation, family care program, supervision, community interpretations and social-recreational programs.

The program outlined above is realistically based on successfully operating programs here, and in other countries. It will be noted that this does not require a building program but instead is designed to keep the child in the home or to return the child as soon as he is ready, where it is least expensive to care for him and best for his own happiness and achievement. Wherever possible he will be earning at least part of his keep, to the benefit of all. The money for the program would be expended where it is most effective, namely, on trained personnel who, however, will be difficult at first to obtain. The overall savings will be considerable, and the benefits to the community great, in having provided a proper life for the mentally deficient.

APPENDIX A

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