Front cover

Room for Improvement

A better environment for the mentally handicapped

Illustration shows a hospital bedroom with a single bed, desk and chest of drawers. The walls are decorated with personal posters, rosettes and photos. The shelves and surfaces are covered with personal objects. The curtains, bed clothes and wallpapers are a cheerful pink with flower design. The owner of the room is tending to pot plants on the desk in front of the window.

Title Pages

‘Society is willing to spend money on the design of environments that maintain life, but not on those that maintain dignified behaviour.’

O.R Lindsley, professor of education,
University of Kansas

ROOM FOR IMPROVEMENT a better environment for the mentally handicapped

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Room for Improvement is a general introduction to ‘a better environment for the mentally handicapped’. It does not contain detailed proposals. The Centre on Environment for the

Handicapped is working on a series of broadsheets containing practical design guidance for architects on facilities for long-stay patients. If you would like to be on the mailing list for the publication programme, please write to the Director,

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This book is not a blueprint. It is not precise in all its parts. It has been produced to convey an idea, that mentally handicapped people are entitled to dignified, homelike

surroundings which will give them fuller enjoyment and will also help them to learn how to live.

Most of the ideas portrayed are not original: they stem from a general awakening of progressive opinion, from the practical experience of many who care for the mentally handicapped, and from the studies of researchers.

Every proposal made in this book can be realised within the terms of the Government White Paper, Better Services for the Mentally Handicapped Cmnd 4683.

James Elliott

Kenneth Bayes

London, 1972

Contents

The Government View

Many types of care

Better Services for the Mentally Handicapped divides the responsibility for residential care between the health service and local authorities, but it stresses that they have to cooperate all the way if they are to produce a truly comprehensive service.

The health service is to provide for those who, because of physical handicaps or behavioural problems, require special medical, nursing or other skills.

The local authorities are to provide residential care for all the others.

The White Paper suggests a number of possible ways of achieving this:

- By the health service in
- existing handicap hospitals, which are to be reduced in size, and upgraded
- in new separate small or medium sized (100-200 beds) hospitals or hospital units working closely with existing hospitals for the mentally handicapped or with general hospitals
- in small units, preferably sited in a residential area. Some units might be for residents who require little medical or nursing care, others could accept a cross-section of people of all degrees of mental handicap, from mild to profound.
- By the local authorities
- in various types of residential home giving a wide range of choice of placement, according to the age, handicap and degree of social independence of each handicapped person.

One quality of improvement

The White Paper recognises that there are different opinions on the validity of some of these methods of providing care and does not commit the Government to any final view. But it commits itself to a very positive statement about the quality of environment needed. Whatever the pattern of care, whatever the degree of handicap, whether the site be in or out of hospital, the residential facility is a substitute family home, and the overriding principle of homeliness must apply. So it should:

be known by its own individual name or street number, as any other house is create a family atmosphere, where individuals can develop within a small group and with their own interests and possessions encourage residents to do the sort of household jobs people normally do in their own homes as far as their handicaps permit separate children from adults not usually separate the sexes have single rooms for most adults and no rooms of more than four beds have plenty of space for recreation, indoors and out of doors enable its residents to use local parks, sports grounds and shops be small, for a maximum of 25 adults or 20 children.

The size of the problem

That is what the White Paper says about quality; but a great many new homes will have to be built, and old houses bought and converted, before these aims can be realised.

The change of emphasis in the White Paper means that, eventually, 35 000 places for mentally handicapped people will have to be found in the community. The diagram below sets out the size of the problem.

Diverse but homely

The White Paper insists on homeliness everywhere but it allows, and even encourages, a diversity of experiment in patterns of care, types of building, and siting.

In exploring the wide variety of choices, this book tries to show some of the ways by which this much needed quality of natural homeliness can be introduced into any place where mentally handicapped people live.

Most people already working with the mentally handicapped are well aware that a homely situation can help the handicapped to learn more readily ; but a few may question whether such an environment is suited to those among the mentally handicapped who may be destructive, or violent, or dirty, or generally inadequate.

Yet there is general agreement that the poor environment of past years has been the direct cause of much under-functioning ; and experience is daily showing that people with even this degree of handicap can be helped by a more natural environment to develop improved appearance, improved habits, and better performance.

Learning to Live

The mentally handicapped person needs normal living conditions, with opportunities for learning, practice and experience. He needs to learn how to live. He not only needs these things: he has a right to them.

His home - the place where he eats, sleeps and spends most of his leisure time - is the natural place for him to learn those self-help skills which could make him a more capable and independent person.

And these learning opportunities can be used by care staff just as much as a workshop instructor might use tools to help apprentices to learn. For that's what a good domestic environment should be: not a magic wand, but a good working tool in the hands of those who are trying to educate the handicapped.

Until now, the design and size of many living units have often left staff with no option but block treatment and regimentation, and these have made the mentally handicapped person too dependent on staff for many simple activities of daily living: robbed of the chance to learn, his initiative, already low, has been sapped still further.

A domestic and informal living unit will not only be better to live in: it will abound in a variety of tasks of different levels of complexity which will provide natural training and learning opportunities. Perhaps the mentally handicapped person will one day be independent; perhaps he will never be able to do much more than contribute a tiny bit of help in the home. Whichever way it is, he still needs to develop what skills he has in a normal and domestic setting. He needs a chance to practice normal patterns of behaviour. This will not only build up his self-respect, but will help him to become a more acceptable person.

A small, homely setting is also more agreeable for staff, who will find it much easier to help the mentally handicapped in the sort of home they themselves are used to. It will enable them to see each handicapped person clearly as an individual, as an ordinary person who happens to need some special care and help.

But this chance will be missed if the staff themselves, whether in hospital or social services, fail to adjust to a non-institutional pattern of work and life.

They will need a lot of encouragement, and perhaps some extension or enrichment of training. It's not much use changing the buildings and furniture if staff aren't able to change their methods at the same time. And staff won't be able to give of their best unless management is prepared to decentralise authority so as to encourage staff to run the living units as if they were their own homes.

Homeliness is for Everyone

Because the mentally handicapped person is capable of growth, development and learning, he needs a setting much like that of an ordinary home, but with some special features to compensate for his handicap and to help his development.

It would be a house and look like one, inside and out, self-contained and not too large, with ordinary domestic windows and doors. It would have its own front door with a warm and welcoming hall inside.

The spaces would be domestic in size and atmosphere.

There would be no standardised colour schemes throughout the residence.

There would be a variety of furnishings between rooms, some old, some new; and lots of objects around belonging to those who live there.

Fittings and fitments would be domestic in character.

It would mostly have single bedrooms, each with its own character and personal clutter.

The kitchen and laundry space would be of a household character.

People in the house would dine in small groups, like any ordinary family, and there would be a comfortably furnished sitting-room.

The WCs and baths would be as in an ordinary house, with customary privacy.

The home would expose the resident, unless very severely handicapped, to the average household risks, for example, stairs, hot water and kitchen equipment.

But what about the very severely handicapped?

There are three groups of people who present very heavy and at times almost insoluble problems:

those with a very severe physical handicap

those with behaviour disorder which is either dangerous or highly disruptive to others

those with marked antisocial habits and whose degree of retardation makes them almost inaccessible.

They all need a comfortable home, like anybody else.

It could be good for staff morale if some of these very heavily handicapped men and women were among the first to have a new home. But providing it presents some real problems.

People with severe physical handicap, but without severe behaviour problems, shouldn't be excluded from a group simply because of their physical disability. Most homes, whether run by health services or social services, can be planned so as to help disabled people to join in with the others.

This way, a good cross-section of handicapped people can live together, if they wish. Even though only a small number may actually need wheelchairs, any home for the mentally handicapped should be planned so that a wheelchair can be used. Adaptations need not be very great, and a domestic atmosphere can easily be preserved.

In planning a newly-built home for a concentration of people with severe physical handicap, it would be wise to provide specially for a fair number of wheelchairs or carriages - plenty of storage space near the entrance, and plenty of room for manoeuvre.
Residents should be encouraged to leave their outdoor wheelchairs at the entrance, to use other mobility aids, or lighter domestic wheelchairs, in the house, and if possible to sit in the kind of chair which has legs, rather than wheels.

Even the most severely physically handicapped people should have some change of scene in the day: easy communication between bedrooms and living areas and good access to the garden will make this practicable for the staff.

But the problems become very difficult indeed when planning a home for those who are occasionally disruptive or dangerous, and those who display disagreeable and antisocial tendencies. There's still the same deep need for homeliness. The problem is how to balance the technical demand for special care with the human need for homeliness. There is much uncertainty as to what might be the best approach.

Bedrooms should be within easy access of night staff, but observation panels are only rarely needed: night staff could be helped by a microphone system not unlike the baby-sitting device used in family hotels. A bed placed lengthways against the wall is often reassuring ; sometimes protective devices to guard against falling out of bed can be made from wood to fit on ordinary bedsteads. Only exceptionally need the bed be of hospital pattern. People with behaviour disorders, or antisocial habits, won't be helped

by spending their time in one large day room. They need a series of smaller rooms, to allow for varied activities and varied kinds of behaviour. Furniture and equipment should be domestic in appearance, but robust enough to avoid frequent damage. Simple but strong furniture of wood, metal or synthetic materials can be found in many domestic ranges.

Some of these residents will be incontinent, or will need assistance, and this will demand special features in the design and equipment of bathrooms. WC and washing facilities must be placed for quick access from any part of the house. Extra large quantities of linen and clothing, and special facilities for washing and storage will be required.

Windows in play spaces may have to be in toughened glass, and in upstairs rooms they may have to be restricted in their degree of opening.

These are only suggestions. Not enough is yet known about the potential of those handicapped people with antisocial habits or whose behaviour is severely disordered ; we need to explore and learn more about how they will respond to intensive training in a more normal environment. Staff with much practical experience should combine with researchers to undertake further studies, or, better still, practical experiments : for example, in the use of very detailed programmes of activities for individuals, or the development of psychological methods of changing behaviour, or the manipulation of environment.

Learning through doing

Many frustrating and seemingly insurmountable obstacles face the mentally handicapped person, and if he doesn’t encounter things which take his interest, his handicap will only get worse. The spark of interest is more likely to come in a natural way, in the home. Better to learn to handle, and even name, the different contents of normal domestic spaces - kitchen, laundry, bedrooms, bathrooms, sitting-room, dining-room - than to be forever surrounded by special equipment in special places, however colourful, stimulating or efficient.

The sitting-room needs to be quiet and comfortable. Even in a home for children this room should have at least some domestic furniture of adult type, and should be used for quiet family activities. This is the place to put the TV - rather than in a special TV space - provided it is not left on all day to keep people amused. It should be on in between other activities, not instead of them.

A children's house needs a play space, with a very different atmosphere from the sitting-room. This is the place for lots of stimulation; for bright posters, and drawings on the wall, and all the fun of water play, sand and bricks. It's not a room to keep very tidy, and it will need robust interior design if the children are to feel free and uninhibited.

The mentally handicapped person needs to become conscious of having become adult: equally important, he needs to pass through, and enjoy, an adolescent stage. He needs to move from a children's house to a more adult environment. He still needs an ordinary house, but the play space would be replaced by a room for hobbies. Where two or three groups of eight share one home, or one site, these hobbies spaces could be grouped ina separate building of simple, inexpensive construction. Providing it separately means that the home itself can be kept down to normal scale.

Any home needs its garden, and homes for the mentally handicapped are no exception: not a garden which is formally laid out, and has to be kept up by a professional gardener, but a place where people can sit around, or do a bit of planting, or perhaps potter about in a greenhouse. A garden shed is essential. Some parts of the garden should be designed to encourage uninhibited play activity. And for children, especially, the garden should be the kind which kindles the idea of fantasy play, with space for a den, and perhaps trees to climb. If there are residents interested in keeping pet animals, or breeding cage birds, some hutches and cages could be provided, or residents could be encouraged to build their own.

A place of his own

The mentally handicapped person who is groping towards more normal ways needs a place of his own, just as we all do. The importance of this hasn't been realised enough in the past. It's worth giving him a bigger bedroom area, even if some space has to be lost elsewhere. For this is his bedroom - and it must be his place. It isn't just a room to sleep in, it's something else besides: a place where he can relax, or do nothing, or invite friends into; or a place where a child can play, or make a domestic shambles and be taught to clear it up himself.

It isn't enough just to provide a single room to be used only at bedtime. The mentally handicapped person must be allowed to use it, within reason, how and when he wishes. This territorial need will not be satisfied unless he is in control of this place. When he is there, he shouldn't have to mix with anyone else, unless he wishes.

A private room is the place where the mentally handicapped person can actually control his own environment. So there's no need for his light to be controlled from the corridor, or for his every movement to be under observation through a window.

His bed might be old-fashioned or a divan or a convertible couch though if he has severe physical handicap his bed and other furniture might need special adaptations or gadgets. And in a very few cases he might do better with a hospital bed. A modern one.

He'll keep his clothes in good order if he uses a real wardrobe - perhaps an old-fashioned one, perhaps a built-in cupboard, but not one of a row of steel lockers, or a drawer under his bed.

He'd like something by his bed to put things on and to keep things in. It might be a small table with a drawer, a locker attached to the bedhead, or a dressing-table, but not a hospital locker, however carefully designed. And he would be the one to keep the key.

His bedroom might be furnished with a variety of things, even some old and second-hand stuff as in an ordinary home. Perhaps his own family would like to provide some of his furniture, and he himself could be encouraged to save to buy his own things.

And his bedroom would look different from the others in the home, and somehow reflect his own character and taste : such things as the mirror, or tooth mug, or bed cover would be just that bit different from others in the home. No doubt the lampshades could be almost any shape and colour except standard issue for hospitals or offices.

Purchasing staff may feel hampered by this lack of uniformity in specification. But a best buy in terms of price or even durability may not prove a best buy if it does not meet the developmental needs of the handicapped individual. A purchase which is technically efficient, but has the inadvertent result of inhibiting learning, is not an effective purchase. Of course, some bulk buying is a best buy – for example, sheets, bedding, towelling - because these things don't hamper individuality unduly.

And a good regional or national contract can offer wide local choice by means of specially negotiated wholesale discounts on a wide range of items generally supplied to private households, for example, furniture, carpets and soft fabrics.

Over and above this, great variety and individuality can be achieved by allowing each living unit a small budget to spend locally and freely on the little extras - cushions, curtains, coffee tables, pictures, chinaware, bed covers, and so on - which all go to make a house into a home.

Furnishing homes for the mentally handicapped presents a great challenge to the supplies manager: his ingenuity and sympathy can help to create real homes, every room that little bit different.

What it adds up to is this: if the handicapped person is going to learn the right way to go about things this won’t help (picture of a uniform hospital ward with lots of identical beds) but this might (picture of a “homely” individual room with personal artifacts)

Sharing a room

In an ordinary family, children often share a bedroom. Sometimes it’s also a playroom, and becomes a kind of kingdom, where the young make their own decisions. You can follow the same idea in a children's residential unit, if rooms are shared by not more than four people.

If you have to spend a lot of your life in bed or indoors, it’s good to have the companionship of others. Life in a single room can be pretty stifling and unstimulating. So for severely physically handicapped adults, a shared room may be a good idea: up to, say, four beds, but not more.

Younger and more active people often like bunk beds. This is fine if the space created is used as living space. It’s all wrong if the space is used for putting up yet more beds.

Even though he shares a room, the handicapped person still needs his own territory, his place of ultimate retreat - his bed space. If a bedroom has to be shared by four people, it is better for some of the furniture to be shared, for example, a single wardrobe unit with separate hanging spaces inside, one dressing-table, one table, one large rug, rather than having four of everything which gives a regimented look. Learning to share some things is a good experience and if the occupants are not happy, or are unable to share in this way, then they probably need a single room, anyway. In a small unit, staff can be sensitive to individual needs and can help preserve a balance between private and shared property.

But it’s better to get away from sharing, if at all possible. Most adults and adolescents, and quite a number of the older children, really need a room of their own to help build up their self-reliance. And anyway, they are entitled to it.

Why small groups?

Even a person of normal intelligence would find it hard to cope with life in a group of 20 or 30 people, surrounded by so many faces, bombarded by so much noise, sharing almost everything with so many others, and competing with them for attention.

In a small group - 12 would be the absolute maximum - and in an environment scaled to the needs of that group, the mentally handicapped person gradually becomes familiar with, and learns to control, a small secure world. As he is sharing with only a few people, he can take pride in the fact that the things he does actually affect his surroundings and his way of life. You don't need special rooms in the home for club or sports activities. They don't belong inside the home. If separate living spaces are created for small groups, they can be warm and friendly as in a private home. Putting up with irregular or sometimes inconvenient spaces is one of the necessary learning experiences of life. Usually the members of a small group, even though handicapped, can learn to respect each other and to understand when to be noisy and active and when to be quiet. A room with 50 people in it can be a jungle: if mentally handicapped people are to be helped to grow, they will need to be in small groups. In this way, staff can see people as people and will make a much more purposeful contribution to the socialisation of the whole group. When the home is small, it is possible for staff to take much more interest in making a homely environment which teaches at the same time. They need lots of scope to choose, and even to buy, what goes into the home. They will need to be free to make quick decisions, very often off the cuff, if they are to do this.

Personal cleanliness

A bathroom is a most important place — not just for a scrub down — but the place in which any growing person has a lot to learn about himself and his personal care.

An ordinary family usually shares the WC and bathroom: washbasins in bedrooms are still rather a luxury. If the mentally handicapped are grouped on a family basis, it's reasonable for them to share in the same way. Washbasins in bedrooms would be handy, but not essential. In fact, they can even look a bit institutional.

In a larger grouping, there's a risk of regimentation and block treatment. So it's very important for each set of four or so people to have its own WC and bathroom.

Even though two bathrooms may be provided for a group of, say, eight men and women, there's no need to have one for women and one for men, unless that is the particular wish of the household.

In a new building there's no excuse for having several WCs en suite. A suite consisting of a separate WC together with a bathroom which contains another WC is a good module, if the suites are properly distributed.

Some people will still be trying to overcome incontinence, so they want reasonably easy access to WCs, upstairs and down ~as is quite normal in a small group home anyway. With a WC within the bathroom, staff have room to help in toilet training.

Sanitary fittings should be of normal household variety. Ordinary doors should be used, though the opening should be wide enough to admit a Sanichair. There is no need for special signs: they wouldn't be found in a home. There should be a bolt on the inside. But where there are young children, or very dependent adults, it's wise to have some kind of device for opening the door from the outside.

More and more people appreciate a bathroom shower. Children love them, provided staff aren't too fussy about wet floors. Some nervous people need to be prepared for the novelty. Grab-rails and non-slip devices give confidence, and there should be a really reliable control of the water heat. Usually, the simple hand spray attached to the bath taps is perfectly adequate. Shower cubicles can help some of the physically handicapped, too, if they are shown how to use them properly. Otherwise, staff will struggle on with seemingly too few baths and too many unwanted showers without the handicapped people ever realising just what they are missing. But not everyone with physical handicap can manage in a shower. Most homes should have at least one bedroom on the ground floor, and a bathroom with a WC adjacent to it, so that physically handicapped people can be included in the group at any time. There should

be room for someone in a wheelchair to move around, and for staff to work with individual people. The bathroom may not be specially equipped at first, but it should be possible, when individual needs emerge, to put in special bathroom fittings and structures: these need not be complicated pieces of masonry.

A bidet is probably a much more useful piece of equipment than is generally supposed, and the possibility of installing one should be considered. But residents need to understand its use. Ordinary domestic detailing and finishes should be used where possible. Why shouldn't a bathroom be warm and friendly?

Unacceptable toilet habits easily mark off the mentally handicapped individual from the rest of the world. If he is going to learn the normal way of going about it this won't help (illustration of a uniform hospital bathroom with a row of baths) but this might (an illustration of a bathroom, bath has a shower curtain, there is a rubber duck in the bath, a more homely space).

Home is in the kitchen

The kitchen is the heart and centre of activity of most ordinary family homes. It's a great pity that it's an unknown land to many mentally handicapped people. It has so much to offer. Helping with the kitchen chores should be as much a part of the way of life for the mentally handicapped as it is in an ordinary home, so a homely kitchen is called for, with simple and comprehensible cooking equipment. The designer should use warm colours and natural materials and staff should have a reasonable budget to spend on some of the attractive kitchenware available nowadays.

The kitchen can still be equipped on a family scale if it doesn't have to serve more than 12 people, but above that number the character changes: grillers, mixers, potato peelers, deep fish friers and dishwashers all tend to be heavy duty models.

They may well be efficient, but they don't help the mentally handicapped to learn to look after an ordinary home. Instead, residents find themselves boosting the labour force in tedious tasks; or they may even be kept out of the kitchen altogether, because it has become too dangerous for them.

A mechanised kitchen of this kind, to serve say, 24, may well cut down labour costs, but it may prove more expensive to install than three domestic kitchens for eight each. The same applies to laundry equipment. Heavy linen and bedding would probably go elsewhere for washing, but a domestic washing machine would encourage residents to launder smaller articles and personal clothing themselves — a good: learning

experience. Integration of the sexes might be accelerated if the men learn to inveigle the women into doing their ironing and mending for them - yet another learning experience.

Ways can be found to enable houses for the mentally handicapped to include a simple domestic kitchen: it's not just a warm and friendly work place, but also a vital piece of training equipment. For instance, the more complicated items for some meals might be partly prepared in a central preparation kitchen run by the local authority or health service, but be cooked or finished in the house kitchen, with other food which has been prepared there. In

Scandinavia some whole meals are cooked centrally and delivered in attractive tureens for the table, to be kept warm in a domestic oven. At other times the care staff and residents use the same oven to make meals themselves. But for all that, good home cooking is the best arrangement of all, particularly if residents can take a hand.

Where the group is small enough, a fairly open planning of the kitchen and dining areas can be useful for training purposes: the two areas relate naturally to one another. Even if a kitchen for 24 is unavoidable, there could at least be areas for separate groups of, say, eight people to prepare their own simple snacks and drinks.

Sitting down to a meal brings the family together after the varied activities of the day, so atmosphere matters a lot. If a reasonable number of the residents can feed themselves, or be taught to do so, they and the staff should eat together, round a family dining-table. In fact, the number of people who can eat comfortably together, and yet have adequate opportunity for training in table habits, is a good determining factor for the size of the group itself. For children who need a lot of attention, a group of eight to ten, including staff, is a good size. In a house for adults, up to 14 round a table can make a sociable setting. But if residents really prefer them, they should have small tables. There should be a sideboard for tableware in the dining-room, as in an ordinary home.

Incidentally, sharing a meal with residents can often be trying and demanding for staff. For them, it is not just a pleasant social occasion but also an essential part of the teaching and training programme. So it doesn't seem fair to charge them for the meal.

Bringing small groups together

Mentally handicapped people, whilst they may treasure the security of their small group, will want to make friends outside it — or they ought to be encouraged to do so. Eight to twelve seems to be an ideal size for a living group, but the harsh realities of finance and staffing sometimes demand that larger numbers of people be grouped together, so that staff can be shared, and various hard pressed units can support each other at times.

It may seem cheaper in hard cash to provide one complete building for the larger group, and to install all WCs and bathrooms in one cluster. But is it more effective? The scattered siting of WCs and bathrooms helps the small group approach, and that helps social training. So it's worth paying a bit more, to get it right. In any case, designers of new buildings have often saved money by centralizing the plumbing and then spent more than they have saved by specifying special purpose-built sanitary and bathroom fittings, sometimes of monumental quality.

To plan one complex building with large communal and service areas, is not necessarily the best way of meeting the need. It may be better simply to build two associated houses, each for 12 - or three houses, each for eight. This would allow each unit to function completely separately if needed, and would reduce fire risk. Or a row of terrace houses could be bought, each with its own front door, but with some internal communication.

Although the White Paper advocates that children be separated from adults, some experienced people think otherwise, and mixed family units have been successfully established in a few hospitals.

Position matters

If you want to set up a home for the mentally handicapped in an ordinary street, whether it's run by the local authority or the health service, there's almost sure to be a protest of some kind. You may wish to explain to the neighbours how very ordinary the mentally handicapped can be, but you won't be helped in your mission if the proposed home looks like a mini-hospital or mini-institution. If it is clumsily sited, say, alongside a fire station or clinic or public weigh-bridge, or wherever there happens to be a spare bit of local authority land, this won't help either. The home needs to be visually integrated into a residential area wherever possible : a house in a street of houses.

The handicapped person needs a lot of services, social, educational and medical. Many of these services could be brought to the home. Others are only required periodically, so these need only be within, say, an hour's travel distance.

But some services will be needed a lot and it could be a very important experience for the handicapped person to learn to travel to those services himself. Children need to reach their special school reasonably easily. Adults need to get to a place of training or work. They all need to be able to reach organised leisure activities. So planners should take a lot of care in trying to site the home fairly close to these services — not so close as to be next door, but close enough to make independent travel a possibility.

Between now and then

And it's not only official services. What about shops, launderettes, playgrounds, cinemas, swimming pools, parks, soccer matches, workmen's clubs, Women's Institutes, churches, chapels, pubs? A great many mentally handicapped men and women and children would enjoy the chance of ordinary entry to these community facilities, and could learn a lot at the same time.

And family contact is helped if a handicapped person lives within reasonable distance of his own relatives. Often, a home will be run by hospital staff, but it doesn't necessarily follow that it has to be on a hospital site, unless this is really more helpful to the handicapped people themselves. It's going to call for a lot of cooperation between local authorities and health services, and even departments within them, if we are to see a service for the mentally handicapped with its interlocking parts sited sensibly, regardless of whether they are run by the hospital, the social services, or the educational services. They are all part of one service for the mentally handicapped - or ought to be.

It's exciting to talk about new buildings, but what about the old ones? Thousands of men and women, boys and girls, are at present living in conditions which handicap the mentally handicapped. Staff find their best efforts thwarted by an impossible environment and by the sheer weight of numbers, even when overcrowding doesn't exist.

A survey by the Wessex Regional Hospital Board showed two-thirds of the adult mentally handicapped people in their hospitals to be continent, ambulant and to have no behaviour disorders: not only this, but two-thirds of these could also feed, wash and dress themselves. These ratios may not be exactly applicable in all areas, but it is generally accepted that a good many hospital residents don't need much supervision in any formal sense, though they need friendly advice and help. Many are ready for residential care in fully staffed small homes, and a few may even be ready for lightly staffed group homes or flats in the community. One day, says the White Paper, the health services will be looking after 26 000 fewer mentally handicapped residents than they are today. But the local authorities are short of 28 000 places. It may take a long time to reach their targets. In the meantime, those 26 000 people now in hospital will need more social education if they are to cope with the more demanding environment outside. Equally, those whom the White Paper plans to keep in health service units will need more education and individual attention than they are getting today. But bad conditions are preventing many hospitals from tackling the task properly.

It is not honest to fob off staff and residents by saying that better times are on the way. Better conditions now will attract new staff and help to retain trained staff because they will see the task as optimistic and therapeutic, not pessimistic and custodial. To tide over, buildings can be improved and upgraded. It's a useful halfway stage but it's not for keeps: it's only a holding action, a way of buying time, whilst improving the quality of service in the process.

In the past, upgrading has often succeeded only in titivating the existing accommodation. It has not helped to make the ward an integral part of the hospital's programme of social education. What it has done is to perpetuate the same old ward atmosphere. The staff are still forced into custodial ways, though the ward may be prettier and cleaner. Yet with the same amount of money, but the right ideas, buildings can be converted to give not only better living conditions, but also opportunities for learning, practice and experience. These are essential to consolidate the learning which has been initiated in specialist departments.

Simple, straightforward homeliness should stil be the aim. But not all old buildings will lend themselves divided into areas the scale of which makes possible a to the formation of small, self-contained groups homely atmosphere. of the kind we have described so far. The major barrier to this is the layout of WCs and bathrooms which have been clumped together for economy's sake to serve 30 to 50 people. Major alterations to sanitary services are hardly worthwhile when the buildings themselves are too big and awkward to be changed. It is better to think about replacing such buildings with homely homes.

But a lot can be done in the meantime. For example, the sanitary arrangements could be changed, whilst retaining drainage outlets in roughly the same position. A number of separate domestic bathrooms and WCs could be installed which would help to teach, by example and practice, the social skills of waiting one's turn and planning and foresight. One or two bathrooms could be allocated for use by each small group and its staff, even though they cannot be an integral part of the small group space.

Areas which were formerly large dormitories or day spaces could each be broken up into small group areas — bedrooms, sitting-room, dining-room and kitchenette - but the advice of the fire prevention authorities should be sought before alterations are made. A front door to the group area from the ' outside, with its own small entrance hall and cloak space, are most important parts of the home and could often be contrived in a ward conversion of this nature.

Storage spaces which formerly served the whole large group could be distributed so that each small group is responsible for some of its own supplies and possessions.

Some spaces could still be shared between groups; for example, a play area for children, a club room or ‘disco’ or hobbies room for adults.

The service is still short of staff, and in most hospitals large groups of residents may have to be brought together in communal areas for joint activities. But just because there are too few staff today, it does not mean that the very large group has to be considered as the right unit for all time. All sorts of variations are possible, if the adapters keep as their target human need, not administrative convenience.

Many hospital staff are already ethusiastic to try out their own new ideas, but sometimes find their efforts blocked by a hopelessly bad environment, particularly if they are in a hospital whose programme offers little hope of new buildings in the near future. In this situation there is all the more need for good and purposeful upgrading of existing buildings.

Action of this kind will accelerate progress and make for more competent residents and more purposeful.

A new outlook for staff

To get the best out of this new kind of environment, many more staff must be recruited and trained. Experience in many progressive units has been that once small-group work is established, in homely surroundings, then new staff are attracted, and existing workers are encouraged to stay.

Time and time again it has been shown that when mentally handicapped people stop living in crowds and start living in small groups, in a domestic environment, their behaviour improves and their happiness increases.

Staff who have struggled with limited help and resources under an institutional regime may at first find difficulty in adjusting to the new environment. It should not be foreign to them, because it will be so much like their own homes, but daily activities will be very different, and if the new home is going to work effectively, the staff must have a share in building a new sort of programme of activity for the people who are going to live there.

Staff should be involved early in planning, so that they can begin to discuss among themselves the sort of daily programme they are going to develop in the new domestic setting. And the architect needs to hear their views before he even sharpens his pencil.

Where staff live

Some mentally handicap ed people can cope more independently than others. Some need more help and encouragement than others. Some need a lot of continuous supervision if they are to get by. The buildings should reflect these different needs and relationships.

Staff might live with the residents as a family. Or they might have self-contained accommodation in the same building. Many will live outside, in their own homes.

The homeliness and personal relationships which develop when the staff live in as part of the family are very good, but staff of a rather special and dedicated outlook are needed, who are able to face continuous and demanding responsibility. It is doubtful whether there are enough dedicated people to stick to a job which demands that they and their families live in one somewhat claustrophobic milieu with mentally handicapped residents.

It may seem an easy answer to have a completely self-contained staff flat within the building where the mentally handicapped people live, though with a totally separate entrance. But there is a lot of experience to show that this is a bad answer: it can easily bring about too strict a separation of ‘us’ and ‘them’. If the residents are of the kind who really need living-in staff and the emotional security they bring, as is the case with most children, it’s better that as many rooms as possible should be shared. Even so, the staff also have a deep need for privacy, and they must have some rooms which are completely private to themselves, though not in a separate wing.

Most adults require very much less support and supervision than this, and a good arrangement here is for staff to have an ordinary house somewhere reasonably near the residential home, but not attached to it. Relationships between staff and residents may lose slightly in intimacy, as compared with the living-in situation, but at least this arrangement recognises frankly the need of ordinary people for an ordinary family life.

It is a good plan for the residential home to contain a bed-sitter or two for occasional night care staff, but this kind of cover may not prove sufficient for those hospital residents who need more continuous supervision.

A few mentally handicapped people could live fairly independently in group homes or flats with staff visiting them by day, and close at hand when needed at other times.

In official schedules of accommodation you often see lists of spaces to be used especially by staff, like offices, interview rooms, medical rooms, staff rooms, staff changing rooms, staff dining-rooms, domestic staff areas. They all make the place a bit

less like home. Are they all necessary? Possibly some of these activities could take place in other spaces in the home without very much inconvenience. It's worth trying hard to do without some of them, and using the space for resident activities.

A different tune

Those who pay the piper call the tune.

In mental handicap, the people who pay the piper are regional boards, social services committees and education authorities. It is the members and officers of these statutory authorities who perceive the need for a new building for the mentally handicapped and who commission an architect to design it. Before the architect can think about designing he has to understand the kind of activity which will be going on in the building. If the members and officials of the authority visualise formal, paternalistic and custodial relationships the architect is hardly likely to produce an informal, developmental and educational environment.

Buildings for the mentally handicapped which are only now being completed display the thinking of an earlier decade. This is nobody’s fault. There has been a tremendous change in professional views in the few years since most of these buildings were planned. Late in the day, we have come to realise that the mentally handicapped are capable of much more than we thought possible. We have seen that they not only like a good environment, but that they do better in it.

Will those who pay the piper now call a different tune?

Conclusion

ROOM FOR IMPROVEMENT has concentrated on the places where mentally handicapped men and women live. It has said little or nothing on such other great issues as the training of staff, the education of the handicapped, or the growth of supporting services.

It has not presumed to lay down any single method or rule for providing a better environment. Instead, it has tried to visualise

some of the many possibilities opened up by a White Paper which may well prove decisive in the history of mental handicap in Britain. If the rich variety of these possibilities is ever to be realised, members and officials of public authorities will need to take a fresh look at mental handicap, and be willing to take an occasional chance on a new, imaginative, but untried idea. Most of all, they will need to give brave support to the efforts of their professional workers as they try to change the climate of public opinion, without which no progress can be made.

In all directions, there is indeed ROOM FOR IMPROVEMENT.