MEDICAL PRACTICE

*Contemporary Themes***First seven years of a new NHS mental handicap service 1974-81**

A MARY MYERS

Abstract

A new community-focused mental handicap service was started in a single-district area health authority in 1974. Almost 90% of all the severely mentally handicapped people in a population of 250 000 are now known to the service. Although two-thirds of longstay inpatients originally admitted with major behavioural problems have had them resolved, the remaining one-third with persisting problems are noted to have spent many years in large understaffed wards before transfer. Specialist services to mentally handicapped people are not synonymous with beds. The learning opportunities during the waking hours of a mentally handicapped person are where professional help must be concentrated, and extensive support services for those caring for the mentally handicapped at home must be set up. Absence of shared philosophies, policies, and planning among the health and local authorities has produced the problems and frustrations familiar to many professionals in mental handicap. Future developments must be based on clearly defined and declared principles.

Introduction

Services required to meet the special needs of mentally handicapped people in the United Kingdom are the responsibility of three statutory agencies—the National Health Service (NHS),¹

local authority social service departments,^{2,3} and the local education authorities.⁴ To these can be added local housing departments and the voluntary organisations. There is no statutory or even formal co-ordinating machinery to guarantee their collaboration; and the variations in knowledge, attitudes, and commitment among agencies and among localities bedevil progress.

This paper describes seven years' experience up to mid-1981 in a community-focused NHS mental handicap service in a fairly static South Yorkshire population.

Rotherham lies 10 miles (16 km) east of Sheffield and is dependent on the coal and steel industries. Rotherham Metropolitan District has a boundary conterminous with the single district area health authority and has a population of 250 000.

In 1974 a small new NHS Unit for mentally handicapped people of all ages (Beechcroft) was opened in the grounds of what was to become the Rotherham District General Hospital, which itself opened in 1978. The unit was planned to provide residential accommodation for some of the 150 Rotherham people then in mental handicap hospitals in Doncaster, Sheffield, and elsewhere, in addition to any new admissions from home. Rather than developing a traditional long-stay hospital unit, however, the opportunity was seized to develop a centre, to which any family in the Rotherham Metropolitan District with a mentally handicapped member could refer for advice and help. During the next three years three off-site hospital hostels (two for adults, one for children) were completed, and these, with Beechcroft, comprised the total NHS accommodation for the mentally handicapped citizens of Rotherham for the foreseeable future.

Rotherham Health Authority

A MARY MYERS, MRCPsych, DPM, consultant psychiatrist in mental handicap (present position: consultant with administrative charge, Sheffield Health Authority, Sheffield Development Project for the Mentally Handicapped)

Principles of the service

The small clinical management team of one consultant, one psychologist, one physiotherapist, and two nursing officers agreed at the beginning on certain basic principles on which the service has since developed.

(1) The pooled professional skills within the area health authority mental handicap services form the predominant resource of the service. These skills are available to all mentally handicapped people of the Rotherham area.

(2) The service aims to identify and assess the needs of all the mentally handicapped people in the area in order to use limited resources effectively and flexibly and to plan accurately.

(3) People with mental handicaps have a complexity of needs that must be identified individually. The prescription of interventions to meet those needs does not necessarily equate to long-term hospital admission, and special residential provision is only one facet of a mental handicap service.

(4) Specialist services to mentally handicapped people are not synonymous with beds; beds are only to sleep on and do not teach life skills. The learning opportunities during the waking hours of a mentally handicapped person are where special professional help must be concentrated. The size and effectiveness of the service, therefore, are not measured by the number of beds present but by the number and skills of personnel available.

Seven years ago only guesses were possible at the nurse staffing levels necessary to ensure continuing training, behavioural improvement, and decent standards of appearance, meals, and leisure for every individual resident. As the nursing establishment had already been allotted to the service, the number of residents admitted was decided gradually and empirically, not on the basis of beds purchased but on the skills and resources of personnel available.

Services to mentally handicapped children and their families

When the Rotherham Mental Handicap Service started emphasis was placed on identifying the problems of children in the hope that early intervention would enable children to continue living at home during childhood, attending their local special school. It was also hoped that some secondary complications of behaviour and under-achievement might be avoided for the future. Initially, paediatric services in Rotherham were limited, so the children referred to the mental handicap service were investigated at the Ryegate Assessment Centre in Sheffield. Much of the subsequent treatment and support was then continued in Rotherham. The opening of the paediatric assessment unit and development of local paediatric services in Rotherham changed the nature of referrals to the mental handicap service: now the problems are usually behavioural and emotional, and no longer primarily those of general developmental delay.

POPULATION SERVED

In Rotherham 153 children aged under 16 are currently identified as severely mentally handicapped. The total school age population is 55 000.

BUILDINGS

The buildings provided for the service include a children's unit at Beechcroft, consisting of three eight-bedded bungalows, associated classrooms, and playrooms; and a hospital hostel (Oak Close) of two eight-bedded houses with two adjacent staff houses, sited seven miles (11 km) away near a special school for children classified as educationally severely subnormal (ESN(S)). This accommodation was planned a decade ago, since when demand for long-term residential care for children has diminished locally and nationally.

SUPPORT SERVICES DEVELOPED SINCE 1974

The support services developed since 1974 are presented in the chronological order in which they may be needed by families.

(1) Very early intervention: the consultant psychiatrist for mental handicap sees the parents of babies with Down's syndrome born in the local hospital within the first two days; the support of other parents of young children with Down's syndrome is offered, and is usually greatly appreciated.

(2) Outpatient clinics are held by the consultant psychiatrist for mental handicap. Referrals are accepted from all agencies, but most are from paediatricians. Management and support are shared between

the paediatric assessment unit and the mental handicap service according to the problems. The general practitioner is always informed of the proposals.

(3) A group for mothers and slow developing children started by the community mental handicap nurse now meets weekly, with the support of the local Society for Mentally Handicapped Children and Adults in one of the hospital hostels in Rotherham.

(4) A monthly evening meeting for parents of school age or younger children with Down's syndrome (Down's group) was started by staff and now meets autonomously at Beechcroft. Newly affected parents are supported by these members.

(5) A monthly evening meeting for parents of children who are moderately heavily impaired (brain-damaged group) was similarly started, and is especially supported by the physiotherapist.

(6) The clinical psychologist and the community nurse have provided domiciliary treatment of behavioural problems for over 40 children with complete or partial resolution of over two-thirds of the problems presented.

(7) Workshops for parents of mentally handicapped children consisting of weekly evening meetings for two to three months, were conducted by the clinical psychologist with colleagues of various professions over a three-year period. The workshops were shared by 40 families, representing almost one-third of all the mentally handicapped children in Rotherham. The parents learnt how to develop self-help skills and improve behaviour in their children: 72% achieved totally or partially the goals they had set themselves.

(8) Short-term care is offered to local families, indeed actively promoted to some, ranging from a few hours to two weeks in either Beechcroft or Oak Close Hostel, whichever seems the more appropriate. Children continue to attend their own schools during that time. There are now 35 mentally handicapped children receiving varying periods of short-term care, including some regular admissions, in six designated beds. The diary is booked by the community nurse.

There is no social services provision for mentally handicapped children locally. The number of families requesting short-term care continues to rise, together with the number of periods each would like. The increasing demand can no longer be fully satisfied, however, because the growing needs of severely handicapped adults are now competing for the same staff resources.

(9) The service is represented at the local education authority reviews of mentally handicapped children aged 14 and over, when their future placement is discussed. Multiply handicapped ESN(S) pupils are placed on the waiting list for adult day care at Beechcroft.

LONG-TERM RESIDENTIAL CARE

Long-term care is defined here as admission for inpatient treatment for five or more days a week over a continuous period of three months or more.

Pending the development of NHS facilities in Barnsley, the Rotherham Mental Handicap Service has had responsibility for the mentally handicapped children of Barnsley AHA since 1974. This accounted for some of the admissions, but since a hostel for mentally handicapped children was opened by Barnsley Social Services four years ago further demand for admission to the Rotherham service was stopped, and some children have been discharged back to Barnsley (table I). During the past year, the six children resident at Oak Close

TABLE I—Numbers of children admitted for long-term care

Source	No admitted (in care of local authority)	Still resident (now >16)	Still resident (16)	Transferred to other hospitals	Discharged*	Died
Rotherham	27 (8)	8	9 (2)	2	7	1
Barnsley	8 (3)	—	3	—	5	—
Sheffield	1	—	—	—	1	—
Total	36	8	12	2	13	1

*Discharged to parental or foster home, residential school, or local authority hostel.

Hostel have vacated the big building and moved into the two empty semi-detached staff houses.

Education—Initially there was a hospital school within the Beechcroft building, but as the number of resident children dropped it was decided to close it, and all the remaining children now attend local ESN(S) schools.

Services to mentally handicapped adults

POPULATION SERVED

Rotherham has roughly 450 severely mentally handicapped adult citizens. They are accommodated as in table II. The figures quoted are the result of a seven-year policy of aiming to identify all the severely mentally handicapped of a static population. In 1978-9 the community health council under a manpower services commission scheme engaged a research assistant to carry out a survey of all the known mentally handicapped people aged over 16 in Rotherham. The information

TABLE II—Residential placements of the severely mentally handicapped adults of Rotherham

Living in Rotherham (n = 340)	
Parental home	230
Group home	14
Local authority accommodation	31
AHA accommodation	65
In Sheffield AHA	37
In Doncaster AHA	58
Other hospitals	7
Total	442

collected on the questionnaire included parental health, physical dependency, and training and treatment needs. The same information has been gathered about Rotherham residents in hospitals elsewhere, and about the new referrals, unknown to the services (five in the past 18 months).

Buildings—The Beechcroft building was intended only for residential provision, but the pressing need for day care for multiply handicapped adults at home was recognised from the start. Accommodation was therefore allotted for an adult day care unit. From the beginning both wards for adults have contained men and women. The two off-site hostels for adults each consist of three eight-bedded houses, both sexes occupying each house.

SUPPORT SERVICES TO MENTALLY HANDICAPPED ADULTS

Outpatient clinics are held weekly. Referrals are accepted from any source, and the general practitioner is always notified of the outcome. Eighty-seven per cent of the mentally handicapped population of all ages in Rotherham have now been identified as outpatients or inpatients and their developmental and domestic problems documented. Roughly 50 new and 100 follow-up outpatients are seen annually.

Beechcroft adult day care unit—This unit provides a service to profoundly and multiply handicapped adults of all ages who live at home and are currently ineligible for adult training centres. They travel daily by ambulance and receive physiotherapy, occupational therapy, daily bathing, and a lively social programme. The unit is allotted its own accommodation and staff and has 20 places.

Domiciliary treatment of behaviour problems is provided by the psychologist and community nurse, but the claims of children have left them little time for adults. Some home visits have included overnight treatments of severe night-time problems.⁵

Short-term care is available in four designated beds at Beechcroft and two in each adult hostel: the diary for them is held by the community nurse. The demand continues to rise.

Advice to the three adult training centres is available on request.

LONG-TERM RESIDENTIAL CARE

The initial intake of adults to Beechcroft consisted of a mixture of transfers from other hospitals and admissions directly from home. The criteria for transfer were severe handicap, age under 45, and active family contact. The admissions to the hospital hostels were from the same sources, but with a wider age range, reasonable mobility, and the capacity to function in the local adult training centres.

LIFE STYLES IN LONG-TERM RESIDENTIAL CARE

Beechcroft is on the district general hospital campus, and its catering and domestic services are supplied from there. The hospital hostels,

however, have an ordinary kitchen in each house, are self-catering, and the life style has developed more usefully. The original complement of cooks and cleaners were absorbed into the nursing establishment of the hostels, and all staff are concerned with all residents in all activities. Every situation is used as a learning situation, from buying the groceries or cleaning the windows to learning social skills and managing fits.

Every resident leaves the ward or hostel for at least part of each week-day. The most profoundly handicapped are included in the occupational therapists' programme in Beechcroft. Hostel residents attend the local adult training centre but stay at home one day a week for intensive domestic training.

All residents in the service, including the most handicapped, go out in very small groups to the leisure centre, pubs, and cafés in the town, where they are no longer subject for comment. They buy their own clothes locally: the development of an appropriate dress sense is part of their training programme and is directed by the beauty therapist (a "technical instructor") in the occupational therapy department.

WRITTEN OBJECTIVES

All residents undergo annual multiprofessional reviews, at which the various objectives for them are decided and recorded and the relevant means and staff for achieving them are identified ("individual programme plans"—IPPs in the United States jargon). The objectives, failures, and achievements have been recorded annually for about five years for most residents, and many staff, including the unqualified, have become quite experienced at individual programme planning.

Staffing of the service

The original establishment has increased minimally over the seven years.

Medical—One whole time consultant plus 7.5 general practitioner clinical assistant sessions.

Psychology—Two senior clinical psychologists (but only one in post most of the time).

Occupational therapy—Two occupational therapists plus two technical instructors plus seven occupational therapy aides.

Physiotherapy—1.5 seniors (also serving the ESN(S) schools).

Social work—One whole-time specialist worker level 2, established in October 1980.

Nursing—One senior nursing officer since October 1980, three nursing officers (including one serving the community), 13 charge nurses, 23 other qualified nurses on the register or roll of nurses of the mentally subnormal, and 67 nursing assistants (including nine from hostels' housekeepers' establishment).

Only the Beechcroft domestics wear uniform. The outpatient and domiciliary work has been performed by three colleagues—the psychiatrist, the psychologist, and the community nurse, with the addition of a social worker during the past year.

STAFF TRAINING

Student and pupil nurses training in mental handicap are received on placement, as are students from general nursing, social work, medicine, occupational therapy, and other professions, for shorter spells.

Great emphasis is put on in-service training to meet the work needs of all types of staff in order to promote imaginative programme development for their patients.⁶

Number of places/beds

The principle has been established that to guarantee a good standard of care the number of patients admitted will depend on the severity of their handicaps and the numbers and skills of the staff serving them.

For adults Beechcroft now has 31 long-term residential places plus five beds for short-term care and emergencies. The two adult hostels are currently staffed for a total of 32 long-term residents plus four short-term care beds.

For children, Beechcroft is staffed for 10 long-stay and four short-

term care places, and the hostel has six long-stay and two short-term care places.

The adult day care unit has 20 places and serves 23 families.

Progress of patients

INDIVIDUAL PROGRESS

Mentally handicapped hospital residents are crudely classified into four groups of dependency by the Development Team for the Mentally Handicapped.⁷

Group 1—Competent at self-care, ambulant, continent, and present no problems.

Group 2—Almost completely self-sufficient, but with mild behavioural problems that could be corrected: continent and ambulant.

Group 3—Continent, with lapses at night; may be mildly overactive with some behavioural problems. Require more supervision than groups 1 and 2.

Group 4—Severe double incontinence, multiple physical handicaps, severe epilepsy, extreme overactivity, self and other directed aggression.

According to this classification, progress has been achieved in most long-term residents, including those severely handicapped. Of the present 31 long-term residents in Beechcroft, 29 have been there over three years. Eighteen remain in group 4 but nine have improved to group 3. In the hostels of the 31 long-term residents, 15 (48%) have improved to group 2 and seven (23%) to group 1. Thirteen other residents improved sufficiently to be discharged to local group homes supported from the hostels.

FROM BEECHCROFT TO THE HOSPITAL HOSTELS

*Better Services for the Mentally Handicapped*⁸ and the Sheffield Feasibility Study Report⁹ both described differences between patients needing a hospital, a hospital hostel, or a local authority hostel placement. In Rotherham a difference in dependency between residents of the hospital hostels and the local authority hostel does not exist. In Sheffield the same finding has been described by the evaluation research group.⁹ Locally, the difference between the two types of hostel has not been in the type of residents but in the range of professional skills available to them.

Beechcroft and the hospital hostels were originally planned and staffed with the concept of two levels of dependency to be provided for separately, and they have operated in that way since inception. As residents in Beechcroft have improved their self-help and social skills they have moved out to a hospital hostel to continue their training. Predictably the resident adult population in Beechcroft has become almost uniformly one of high dependency, with a developmental age averaging 18 months, and few with any useful speech. This policy of segregation by ability level is now considered a grave mistake, but so many other planning assumptions had to be challenged initially that this fundamental one went unquestioned at the time.

The outstanding problem is the absence of any exit from the hospital hostels. The area health authority has supported Rotherham MIND in establishing and supervising four group homes, with the co-operation of the local authority housing department and the South Yorkshire Housing Association. Joint financing money was used to help equip them.

Nevertheless, only a few hostel residents are capable of that level of independence even after intensive preparation. There is one local authority hostel for 24 mentally handicapped adults and one home supervised by a landlady, but they are both full, and there are no other residential arrangements available. There is thus no movement from the hostels, which could eventually provide places for the heavily handicapped in Beechcroft.

PATIENT THROUGH-PUT

In the seven years there was a total through-put of 36% of all long-stay residents—that is, children and adults—using a total of 78 staffed beds. Some of this was due to the relatively low dependency of some early admissions, people who would not now be considered eligible in competition with those more handicapped now known to the service. This through-put has virtually stopped until further developments occur in the area health authority or local authority.

WAITING LIST FOR ADMISSION

The 22 multiply handicapped adults who use the day care unit and short-term care form the waiting list for permanent admission to Beechcroft. Several have elderly and frail parents whose death will precipitate the admission. No family is seeking permanent admission at present, but the lack of any vacancies currently is a constant anxiety to parents and staff. Probably all the highly dependent mentally handicapped people in Rotherham are already known to the service and are receiving some support from it. It should be possible to plan accurately for them.

There are still 95 Rotherham adults in the Doncaster and Sheffield hospitals, with about 60 awaiting transfer back. An area health authority mental handicap strategic plan drawn up in 1978 envisaged accommodation for them and for additional adults from home, over the next 10 years, in ordinary housing. Financial constraints have left that plan undeveloped. There appears to be no local authority residential plan for the mentally handicapped.

Some lessons learnt

ABOUT CLIENT NEEDS

(1) By definition all mentally handicapped people are slow learners, and their problems include absent or maladaptive learning opportunities. Some have specific biological impairments to learning—for instance, locomotor, body image, or special sense disorders—for which special treatment, training, and aids are required. Many more have none of these complications but have little or no speech, with possibly minimal inner language. There is increasing awareness among staff of the necessity of communication skills and of the value of signing systems—for example, Makaton, Paget-Gorman, Bliss¹⁰—as an alternative or adjunct to speech.

(2) Objectives for each client must be identified, but the small steps towards them must be defined and given a time scale. The application of “goal planning”¹¹ has given both residents and staff new skills.

(3) A few present with major behavioural problems: the behaviour may be learnt, psychotic, epileptic, emotional, or a combination, in origin. Accurate diagnosis can be extremely time-consuming. The high level of disruption and desperation produced by one or two such people, however, demands the necessary professional attention. With the setting of written objectives (albeit imperfectly), over the past five to six years the longstanding disruptive behaviour of several residents has improved. In Beechcroft there are 23 adults admitted three or more years ago with major behavioural problems. Only seven continue to present the same problems. Of those, one profoundly handicapped patient was admitted from home with a severe recurrent affective disorder, still poorly controlled: the remaining six had all spent about a decade in understaffed large wards elsewhere. No other patients admitted from home in the past seven years have presented such intractable behaviours. From the survey, it was learnt that of the Rotherham patients remaining in hospitals elsewhere, 20 still present with major behaviour problems; further details of diagnosis and management were not sought. Thus a total of 27 severely mentally handicapped adults from a local population of 250 000 currently present with behavioural problems: intensive individual study and management might reduce the number. These patients present an exciting professional challenge.

(4) The communal environment, although more pleasant than conventional wards, is visibly disliked by several residents, who seek to avoid constant company and noise. Physically, it is difficult to organise that degree of separation, and exasperation sometimes erupts among residents.

Apart from the seven disruptive patients, with the proper provision of personal care and training staff all residents could live in small groups in ordinary housing. Physical handicaps, the need for help with feeding and hygiene, do not indicate the need for hospital residence: most of the very heavily handicapped in Rotherham in fact live at home and attend Beechcroft daily. The death of a parent is not a clinical condition warranting hospital admission.

ABOUT NEEDS IN ORGANISATION

(1) Health, social services, and education all have responsibilities for the mentally handicapped. Although joint consultative committees and joint care planning teams are statutory, actual consultation,

planning, and commitment are not. Where mental handicap remains without political popularity, at the bottom of social services' priorities, and joint planning is considered politically unworkable, NHS facilities are expected to meet all crises, including preventable ones. The mental handicap service developed with enthusiasm to meet local needs: it has proved impossible to identify any philosophy, or plan in the local authority, against which to consider NHS developments. When joint care planning consists of allotting joint finance in the absence of any overall plan, the resulting stasis, frustration, and cynicism are bad for clients and staff. Methods of collaboration between health and local authorities exist in many places, but they depend on the local good will of the agencies to do so. For such a vulnerable client group that is just not good enough.

(2) The clinical demands, both inpatient and outpatient, entailing much liaison, on a single-handed consultant per 200 000¹² population are very high. The subject of mental handicap is changing rapidly, with new and old assumptions under challenge. Monitoring and evaluation are essential but not provided for. The role of the consultant in mental handicap will and should change, perhaps in future to the "psychiatry of handicap." The increasing interest of local medical students in the subject is encouraging.

Discussion

The past decade has provided an abundance of publications and initiatives relating to mental handicap, including "Better Services,"³ "Court,"¹³ "Warnock,"¹⁴ "Jay,"¹⁵ and the National Development Group's publications.¹⁶⁻²¹ The Campaign for Mentally Handicapped People has publicised the innovative service in Omaha, Nebraska (ENCOR).²² The Kings Fund Centre has been host to numerous multiprofessional conferences and published papers on mental handicap.²³ The development team for the mentally handicapped has visited 42 localities with advice and recommendations to both NHS and local authority services. Joint financing has been introduced to improve local collaboration and developments. Staffed residential accommodation in ordinary housing has been provided for severely mentally handicapped people by Dr Barnardo's and by statutory authorities in Cardiff and Northumberland. The decade has also seen the appointment of the first professor of special education of the mentally handicapped (Peter Mittler at Manchester) and the first professor of psychiatry of the mentally handicapped (Joan Bicknell at St George's Hospital, London). Severely retarded children have been included in the statutory education system for a decade now. It is wasteful that the knowledge and experience acquired by their teachers have been left virtually untapped by health and social services.

Government now recognises the normal needs of children who happen to have severe learning difficulties,²⁴ but the recognition of the normal needs of adults with the same difficulties still seems to defeat the public imagination. Such concepts as normalisation, devalued people, the civil rights of very slow learning adults, and their advocacy are spreading only slowly. They must be explored and included in the planning and development of facilities, or expensive mistakes will be perpetuated.

Conclusion

Much can be done to improve the life and skills of mentally handicapped people and their families by a relatively small team provided the appropriate skills are recruited. Without a supportive matrix of co-ordinated statutory agencies, however, both modern professional skills and voluntary resources will not be exploited to the full for this very vulnerable group. Future developments must be based on clearly defined and declared principles.

References

- ¹ National Health Service Act 1946. London: HMSO.
- ² Mental Health Act 1959. London: HMSO.
- ³ Department of Health and Social Security. *Better services for the mentally handicapped*. Cmnd 4683. London: HMSO.
- ⁴ *Education (Handicapped Children) Act 1970*. London: HMSO.
- ⁵ Tait T, Brookes M, Firth H. Sleep problems in mental subnormality. *Nursing Mirror* 1976 Jul 15.
- ⁶ Firth H, Barrow D. Training for caring. *Health and Social Service Journal* 1981 Jul 24.
- ⁷ Development Team for the Mentally Handicapped. *Second report 1978-9*. London: HMSO, 1979.
- ⁸ Department of Health and Social Security. *Proposing a new pattern of service for the mentally handicapped in Sheffield County Borough*. London: HMSO, 1971. (MO (MS) 46, development project: feasibility study report.)
- ⁹ Malin N, Race DG. *Residential services for mentally handicapped adults: interim report on stage one*. ERG Reports No 4. (University of Sheffield Evaluation Research Group, Department of Psychology), 1979.
- ¹⁰ Kiernan C. Alternatives to speech: a review of research on manual and other forms of communication in the mentally handicapped and other non-communicating populations. *British Journal of Mental Subnormality* 1977;23, part 1:6-28.
- ¹¹ Williams P, Anderson T, Davison R, Reid M. A model for maintaining ward-based goal planning. *Apex, Journal of British Institute of Mental Handicap* 1981;9:24-5.
- ¹² Memorandum on "norms" for medical staffing of psychiatric services: (2) mental handicap. *Br J Psychiatry News and Notes*, December 1973.
- ¹³ Committee on Child Health Services. *Fit for the future*. Cmnd 6684. London: HMSO, 1976. (Court Report.)
- ¹⁴ Committee of Enquiry into the Education of Children and Young People. *Special educational needs*. Cmnd 7212. London: HMSO, 1978. (Warnock Report.)
- ¹⁵ Committee of Enquiry into Mental Handicap Nursing and Care. *Report*. Cmnd 7468. London: HMSO, 1979. (Jay Report.)
- ¹⁶ National Development Group for the Mentally Handicapped. *Mental handicap: planning together*. Pamphlet 1. London: DHSS, 1976.
- ¹⁷ National Development Group for the Mentally Handicapped. *Mentally handicapped children: a plan for action*. Pamphlet 2. London: DHSS, 1977.
- ¹⁸ National Development Group for the Mentally Handicapped. *Helping mentally handicapped school leavers*. Pamphlet 3. London: DHSS, 1977.
- ¹⁹ National Development Group for the Mentally Handicapped. *Residential short-term care for mentally handicapped people: suggestions for action*. Pamphlet 4. London: DHSS, 1977.
- ²⁰ National Development Group for the Mentally Handicapped. *Day services for mentally handicapped adults*. Pamphlet 5. London: DHSS, 1977.
- ²¹ National Development Group for the Mentally Handicapped. *Helping mentally handicapped people in hospital*. London: DHSS, 1978.
- ²² Thomas D, Firth H, Kendall A. *ENCOR—a way ahead*. London: Campaign for Mentally Handicapped People, 1978.
- ²³ Kings Fund Centre. *An ordinary life: comprehensive locally based residential services for mentally handicapped people*. London: Kings Fund, 1980.
- ²⁴ Shearer A. *Bringing mentally handicapped children out of hospital*. London: Kings Fund, 1981.

(Accepted 11 May 1982)

What treatment is advised for a teen-aged girl with systemic lupus erythematosus?

Treatment depends entirely on the severity of the disease. If there are no renal lesions and the patient is asymptomatic no treatment may be needed. For patients with predominantly cutaneous and joint disease, antimalarials, such as hydroxychloroquine, are useful. For severe flare-ups corticosteroids tailored to the severity of the disease are mandatory. The trend in recent years has been towards a more conservative approach to management. Thus an initial prednisolone dosage of, say, 40 mg daily may be quickly reduced over a period of weeks to doses below 15 mg daily if improvement occurs, with slower tapering and total withdrawal thereafter. For patients with diffuse proliferative nephritis or those requiring high doses of prednisolone to control disease, most doctors would add azathioprine or cyclophosphamide.¹ The prognosis of childhood-onset systemic lupus erythematosus probably differs little from the adult disease, and provided that renal disease is not a major feature the prognosis may be excellent.²—G R V HUGHES, senior lecturer in medicine (rheumatology), London.

- ¹ Hughes GRV. SLE: treatment and prognosis. *Br Med J* 1979;ii:1019-22.
- ² Cairo F, Michielson FMC, Beinstein R, et al. SLE in childhood. *Ann Rheum Dis* 1981;40:325-31.