

A COMMUNITY MENTAL HEALTH APPROACH TO MENTAL RETARDATION *

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PRESIDENT COAKLEY, members and guests of the association, I am going to discuss current developments in psychiatric theory and practice and suggest how they are of relevance to the field of mental retardation. I will refer particularly to the community mental health field, in which I have worked now for a good many years.

First, we are in the midst of important changes in our accustomed ways of looking at illness and disability. Modern psychiatry had its beginning at the time of the great 19th Century developments in pathology, physiology and microbiology, and has traditionally been oriented, as the rest of medicine, to finding *the cause* and *the cure* of various disorders. This has, of course, paid off in many instances, such as with general paresis, nutritional deficits, endocrine disturbances and now in the field of inborn errors in metabolism. Almost by instinct we look for and hope to find single causes for illnesses and disabilities. Undoubtedly there will be more discoveries of single agents, as well as of specific biochemical and psychological processes, which will enable us eventually to control and treat additional specific illness.

But today we see changes occurring first, in our concepts of illness and disability, and secondly, in our approach to control and treatment (1). These newer concepts are of special impor-

tance to those of us concerned with mental retardation. We are beginning to see disease as the resultant of many forces, or factors, and we identify these as biological, psychological, and sociological in nature. Ego psychology and learning theory which has developed during this century has moved from the 19th Century linear cause-and-effect approach, and now views the individual with his mental equipment and personality, his state of health or illness, as the result of interplay of many forces in a dynamic equilibrium. The concept of psychological defense mechanisms forms the theoretical basis for much of our psychiatric practice today (2). In the biological sphere, Cannon's concept of "homeostasis," or physiological equilibrium, has been followed by Selye's current studies on stress and biological defense mechanisms which operate on every level—intracellularly, in the cell membranes, in the body fluids and various organs, including the central nervous system (3).

The application of the new concepts of function is still being developed in the sociological area. We know today with considerable assuredness that lack of mothering and faulty mothering can stunt and warp the development of an infant—and older children as well—in both intellectual and emotional functioning. It appears that lack of proper fathering will also contribute to malfunctioning. We are impressed with the fact that institutionalization—at least in those institutions which do not or cannot meet needs—will result in damage, or malfunction, or lack of op-

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tinum functioning (4). As you know, this has been demonstrated in studies with institutionalized children who have subsequently been placed in homes (5). We know now that the behavior of children results not only from their biology and mental condition, but also from the nature of their physical surroundings and human environment. We are impressed with the fact that certain cultures contribute a disproportionately high number of cases of mental illness, social and behavioral maladjustment and mental retardation (6).

There is no escape from the fact that when we are concerned with mental disability in the clinic or institution, we must *in each case* be concerned with the biological, psychological and socio-cultural aspects as they are uniquely presented by that case. Likewise at the community program level we must, through our community education efforts and organization of services, build programs which can realistically cope with all relevant biological, psychological and socio-cultural factors.

There is no need for me to belabor the point made many times that "mental retardation" is a symptom not an illness. It is a "socio-cultural designation," or label, which when applied to an individual may have various consequences for him, good or bad. But I believe it is important that it be *clearly understood* that "mental retardation" is a symptom only, or at best a "condition," and that when all persons with "mental retardation" are put under one roof, you have at least as much heterogeneity in the population as you have homogeneity, and that many different types of programs and approaches are needed to bring to the population what is best for each person in it (7). For instance, I am sure that many of the educable retarded

have more in common with certain children with neurotic learning disabilities and culturally derived lacks in motivation to learn and in the development of learning skills than they do with the trainable retarded, who for the most part have demonstrable and profound central nervous system damage. Yet we tend to lump them together in our State institutions. We are tempted to isolate community programs, clinics and the like, which are identified as for the "mentally retarded," and to separate them off from our general health, education and welfare services for children. A few years ago we were faced with this problem in Massachusetts, and, after considerable thought, decided to place a new program of nursery training centers for preschool retarded children squarely in the midst of our community mental health centers, rather than to set up a separate system which would perpetuate the dichotomy, "mental illness-mental retardation (8)." The Massachusetts Community Mental Health Centers had for some years been working to develop broad public health oriented programs and had established working relationships with the many community agencies in health, welfare and education concerned with growing children. These include participation with community planning groups, mental health education and consultation services as well as case-oriented clinical treatment and rehabilitation programs (9).

This decision highlighted many problems. First, our good friends in the Association for Retarded Children were distressed, for they felt that their sincere efforts were being frustrated by not having separate clinical and nursery training services devoted exclusively to the mentally retarded and

their parents. Our mental health center staffs, with their mental health associations, also had mixed feelings. They tended to see this new program as over-burdening them with an inappropriate assignment for which they were ill-equipped. I am sure these same reactions would be found in many parts of the country. Actually, with the far-sighted leadership of the mental health center directors and our association colleagues in both "mental health" and "mental retardation," a community program for the retarded is now developing in Massachusetts which is in an integral part of a network of community mental health services. This integration helps in mobilization of all the resources of the centers and communities for each of these cases. As the cases come in, we see a great variety of conditions and illnesses. Malcolm Farrell reported some years ago that 85 per cent of the school-age children referred to the Fernald School Community Clinic services as "retarded" were actually "child guidance cases" in need of psychiatric diagnostic, consultative and treatment services, which require the closest collaboration of many agencies, especially mental health and education (10). The educable retarded are for the most part not so labelled until failure to progress in school is evident. At the preschool level the children labelled "retarded" are much more apt to be those with various forms and degrees of central nervous system damage. I am told, however, that there is a significant number of children in the Massachusetts pre-school nursery program today who have grave emotional disorders—some psychotic—in addition to the children with mongolism and other somatic disorders (11). The broad services of a mental health center however are

no less indicated for this latter group (12).

Community mental health services range from mental health promotion and specific prevention through early diagnosis and limitation of disability with prompt treatment, to rehabilitation or habilitation of those with chronic handicapping conditions (13). If our focus is narrowly limited to those with diagnosed and labelled mental retardation, we are doing two things which limit maximum application of existing knowledge. First, we are assuming a sort of homogeneity when in fact we have many children with quite diverse conditions, and different needs. They then come into a setting which is not usually equipped to provide such a variety of services as is indicated by their needs. We are quite familiar with this phenomenon in many of our programs for special education, both in public school settings and our institutions. Secondly, both programs for specific prevention and provisions for optimum rehabilitation, which must be linked in with across-the-board public health and other activities, cannot get going in isolation. Gruenberg, Eisenberg, Ingalls, Knobloch and Pasamanick, to mention a few, have identified some populations at risk and have suggested preventive measures to be taken (14). These need the involvement of maternal and child health workers in both research and service programs, not just those people indentified as workers in mental retardation. Increased research and the development of control measures should be directed to the specific illness or faulty mechanisms underlying mental retardation, and as such can only be a part of a general effort in public health.

If we apply the notion that we must be concerned with biological, psycho-

logical and socio-cultural factors in mental retardation, then certain principles emerge which will guide us in program development (15).

1. We are concerned with degrees of handicap, or disability. The maximum development of such handicapped persons will necessarily involve all professional groups and community institutions concerned with child rearing and adult life.
2. Treatment involves more than "cure" in the limited sense, to be obtained by a pill or some maneuver or procedure. It rather requires a mobilization of all resources in the community—medical, educational, recreational, social and religious—to help the child and its parents.
3. This view of treatment implies continuity of care, with the child and parents having easy access to helping services when in need. It suggests a breakdown of barriers between institutions and community, with to-and-fro movement of the retarded from institutions to the community and return, using both natural and foster homes.
4. We must encourage research efforts in all fields, ranging from genetics and biochemistry to sociology and anthropology.
5. Finally, we must reinterpret the problem to the public, and continue the vigorous effort to remove the stigma which goes with the label. We must make it clear that what we call "mental retardation" represents the abnormal expression of many diverse biological, psychological, socio-cultural processes which are in actuality part of all of us, and so the concern of us all.

How can we apply these principles in a community action program? Robert Ferguson in his outline for a program in Philadelphia remarks that an initial survey there revealed a striking lack of communication between all the agencies and individuals concerned with retardation (16). This points to a first need, namely, to develop a central information, planning and coordinating group which will provide a forum for discussing mental retardation, bringing together many different

professional and lay people. These people can then develop a common understanding of the issues involved and delineate the proper areas of concern and responsibility for various agencies and individuals. We must remember that few professionals know much at all about mental retardation or feel any concern for it. We devoted, I am sure, no more than a day or so to the subject during four years of medical school. The tendency of most professionals, I believe, in no way differs from that of the general public: to sweep the issue under the rug, to assume the attitudes, described by the Cummings in *Closed Ranks*, of denial, avoidance and isolation (17). Karl Heiser has stated the issue clearly as he says, ". . . it should not be a matter of setting up new and special agencies . . . this is not a special, separate kind of problem . . . we need to educate and train staffs of existing agencies to recognize these problems, and deal with them instead of shoving them aside . . ." (18).

What we want is an informed public which realizes that improved prenatal care and child health services, improved educational services for all children, enrichment of neighborhood resources for our socially and culturally deprived families will have a major impact on the problem of mental retardation. The further growth and development of *all* our health, welfare and educational services, with expansion of research efforts on all fronts, contain major pay-offs for mental retardation. We can look not only for new specific preventive measures, but also for realistic community care and treatment programs which no longer isolate mental retardation as a problem, and which can return to the community an ever-increasing number of men-

tal retardates now in institutions. We may see Heiser's belief come true, that about half those now lost to society in institutions—those "idle and dependent" people labelled "mentally retarded"—can become producers, consumers and useful members of society (19).

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