THE
MENTALLY SUBNORMAL CHILD

Report of a Joint Expert Committee Convened by WHO
with the Participation of United Nations, ILO, and UNESCO

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Geneva, 16-21 February 1953

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THE MENTALLY SUBNORMAL CHILD

Report of a Joint Expert Committee Convened by WHO
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1. Introduction

It is probable that in all societies the grossest forms of mental subnormality have been recognized and given special names. But in communities in which little attention is paid to mental health the severely defective alone are regarded as remarkable. It is only during the last century, and in particular within the last 40 or 50 years in parts of Europe and America, that some consideration has been given to the special problems presented by persons suffering from milder forms of mental subnormality or social incompetence. The need for such consideration has arisen partly owing to the industrialization of society and the consequent growth of cities, partly because of compulsory education, and partly through the demands made by industrialism for rapid occupational adaptation. The increases in the social services which characterize modern society have led to a growing recognition of this need.

Today it is still rare to find existing the conditions which would render it possible for subnormal children to make full use of their limited abilities and potentialities. In school, they are very often educationally more backward than they need be; and in both adolescence and adulthood many of them present serious problems which would not have arisen had they been properly cared for in childhood. These problems are sometimes difficult to deal with in adulthood. But the problems of childhood which lead up to the difficulties in adulthood can be treated with greater prospect of success, or even avoided, given timely and adequate assistance; and it is for this reason that the Joint Expert Committee on the Mentally Subnormal

* The Executive Board, at its thirteenth session, adopted the following resolution:

The Executive Board
1. NOTES the report of the meeting of the Joint Expert Committee on the Mentally Subnormal Child, which was organized by WHO with the participation of the United Nations, ILO, and UNESCO;
2. thanks the members of the committee for their work; and
3. authorizes publication of the report.
(Resolution EB13.R13, Off. Rec. Wild Hlth Org. 52, 5)
Child lays much emphasis on preventive and remedial measures which can be carried out during childhood. Such assistance, to the young child and his family or family substitute, is possible on a community scale only within the framework of comprehensive health, educational, social, occupational, and vocational placement services.

Subnormality is a graded characteristic and some discussion of the problem as a whole is therefore desirable. The committee, however, has concerned itself mainly with the needs of children suffering from the milder forms of subnormality. Hitherto, as already pointed out, it is the gross cases which, in most countries, have received the greatest attention. Their needs are more obvious, particularly because they have frequently in the past been separated from the family and the community; milder cases often remain unrecognized. But the latter are much more numerous and more can be done to train, educate, and settle them in the community. It should be stressed that no programme for the mentally subnormal child will be complete without the necessary efforts being made for his placement in suitable employment when he reaches young adulthood.

In considering the problems of the mentally subnormal child, the committee has been guided by reports of previous expert committees which have discussed problems in some respects similar. Thus, the Expert Committee on Mental Health at its first session declared that the "most important single long-term principle for the future work of the WHO in the fostering of mental health" should be "the encouragement of the incorporation into public-health work of the responsibility for promoting the mental as well as the physical health of the community." The same committee stressed the desirability of concentrating especially on the therapeutic and preventive psychiatry of childhood. They noted that psychological medicine was at present less well-organized to make progress than internal medicine, which not only had treatment facilities for organic disease, but also had in most well-developed countries an organized and to some extent comprehensive public-health service, which "has the duty of attempting to remove from the human environment factors which threaten the physical health of the individual and threaten his physical development." On the other hand, apart from some institutions for the care of those who are mentally ill or seriously defective in mind, there was generally lacking a comprehensive public mental health service.

Two other guiding principles, enunciated by the Joint Expert Committee on the Physically Handicapped Child, seemed capable of being applied to the mentally handicapped and indeed to all children.

Every child has the right to expect the greatest possible protection against the occurrence of preventable physical or mental handicap before, during, and after birth.

Every child also has the right to develop his potentialities to the maximum. This implies that all children, irrespective of whether or not they suffer from mental or physical handicap, should have ready access to the best medical diagnosis and treatment, allied therapeutic services, nursing and social services, education, vocational preparation, and employment. They should be able to satisfy fully the needs of their own personalities and become, as far as possible, independent and useful members of the community.

While recognizing that many children present multiple handicaps, the committee has considered it desirable to limit discussion to those children whose outstanding disability is that of mental subnormality. It wishes, however, to draw special attention to the needs of children suffering from physical disabilities often mistaken for, or complicated by, mental subnormality. Three categories of such children should be mentioned:

(1) those whose physical and mental handicaps co-exist and may have a common cause (e.g., subnormal children who are also blind or deaf);

(2) those whose mental subnormality is a consequence of their physical handicap (e.g., epileptic children who become subnormal);

(3) those having physical handicaps which, if not diagnosed promptly and treated wisely, may be mistaken for and actually lead to mental subnormality (e.g., some partially deaf or spastic children).

These children are not considered in detail here because they require additional and separate consideration. None the less, the basic principles outlined in this report constitute a framework in which their needs should be included; and a comprehensive programme of services for the handicapped must make provision for them. It is necessary to dwell on this point because the special needs of many children with double handicaps are frequently overlooked. (Cerebral palsy, for example, is still often mistaken for idiocy and partial deafness or partial blindness for imbecility.)

Great stress must therefore be laid on the need for diagnosis and treatment in early childhood of those children who might easily be thought to be mentally subnormal if not dealt with wisely.

There is an urgent need for much more research into and discussion of differential diagnosis, treatment, and methods of educating handicapped children.

There is a need, too, for many specialist services to deal with children with differing and, in many cases, multiple mental and physical handicaps. To meet these needs while still considering the personality and individuality
of the child as a whole it is important to discuss the development of programmes for integrating all the services required to make possible the full development of the potentialities of the mentally subnormal.

2. Definition—Classification and Terminology

In few fields of knowledge is there more confusion resulting from terminological differences than in that which forms the subject matter of the committee's deliberations. Some consideration must therefore be given to the definition of terms and the use of words.

The term "mental subnormality" is intended by the committee to describe an incomplete or insufficient general development of the mental capacities. It is desirable to emphasize that it is intended to cover only cases in which general mental development is insufficient. The term "mental deficiency" which is more commonly used to describe the disability of persons suffering from incomplete development of the intelligence is also often applied to conditions in which only the individual's emotional development is incomplete while intellectual development continues up to normal levels. These persons are also sometimes referred to in certain countries as "moral defectives", especially in connexion with certification or commitment procedures. Their disabilities are, however, different in kind from those of persons described here as mentally subnormal; and it is probably preferable to deal with those who have normal intellectual abilities but incomplete or distorted emotional development which leads them into conflict with the law as "anti-social persons with psychopathic personalities" rather than to equate them with the mentally subnormal.

Although it is not possible to draw a sharp distinction between mental subnormality of varying degrees of severity, a traditional and in many ways useful practice has been to divide the condition into three grades: idiocy—the most severe; imbecility—or moderate subnormality; and feeble-mindedness (in British terminology) or moronity (in United States usage)—the most mild. In the USA the term "feeble-mindedness" is used as a synonym for the general term "mental subnormality", whereas in British usage it is confined to mild subnormality.

The picture is further complicated by the fact that in the USA the term "feeble-mindedness" is now coming to be replaced by the terms "mental deficiency" or "mental retardation". In British usage, however, the term "retardation" has a developmental implication.

To standardize the terminology, the term "mental retardation" has been used in this report to refer only to those whose educational and social performance is markedly lower than would be expected from what
is known of their intellectual abilities. When terms are needed to describe conditions in which the mental capacities themselves are diminished as a result of pathological causes, as opposed to environmental causes which may lead to mental retardation, "mental defect" and "mental defective" are used. (Those who suffer from mental defect may, of course, also be retarded.)

The term "mental subnormality" is proposed as a general term to describe the mentally retarded on the one hand, and the mentally defective and those whose mental endowment is so poor that they are remarkable for their dullness even if functioning to the best of their abilities on the other. When it is desirable to qualify the term "mental subnormality" in order to indicate the degree of subnormality, the terms "mild", "moderate", and "severe" are used. All these terms have the great advantage of being purely descriptive; they make no assumptions about etiology or prognosis, but only describe present mental functioning. This terminology does not replace the special technical classifications of the clinician or the educationalist, but it is suggested as being suitable for general practical and administrative purposes where it is desirable to have a common nomenclature which will not provoke controversy.

A summary of the nomenclature proposed, of the terms at present in vogue in different countries, and of the definitions in terms of intelligence-test scores laid down by the Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death is given in table I. The terms proposed by the committee are in the left-hand column. Attention is drawn to the definitions in terms of intelligence quotient (IQ) and mental age contained in the Manual mainly in order to criticize them. Intelligence tests have a useful though limited function in the diagnosis of mental subnormality. They describe only one aspect and it must be recognized that overlapping of the IQs of children who on clinical grounds are in different grades is unavoidable, and that an individual's ascertained IQ may differ from time to time. Two further technical objections make the classification contained in the Manual unsatisfactory. First, no test is mentioned, the assumption being presumably that IQs on all tests are approximately equivalent. This is false. Secondly, the "mental ages" suggested are too high. More-conservative figures would place the borderline of moderate subnormality for adults at approximately the two-year and six-or seven-year levels on the 1937 Stanford Revision of the Binet Test, if this is used, and of mild subnormality at the six-year and nine- or ten-year levels of difficulty.

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### TABLE 1. CURRENT AND PROPOSED NOMENCLATURE OF MENTAL SUBNORMALITY

<table>
<thead>
<tr>
<th>Recommended terms</th>
<th>Current usage</th>
<th>Intelligence level according to the Manual *</th>
<th>Mental age in years (adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of mental subnormality</td>
<td>British</td>
<td>American</td>
<td>French</td>
</tr>
<tr>
<td>Mild subnormality</td>
<td>Feeble-minded</td>
<td>Moron</td>
<td>Débile</td>
</tr>
<tr>
<td>Moderate subnormality</td>
<td>Imbecile</td>
<td>Imbecile</td>
<td>Imbécile</td>
</tr>
<tr>
<td>Severe subnormality</td>
<td>Idiot</td>
<td>Idiot</td>
<td>Idiot</td>
</tr>
<tr>
<td>All grades of mental subnormality</td>
<td>Mentally defective</td>
<td>Ament</td>
<td>Feeble-minded</td>
</tr>
</tbody>
</table>


The question of "borderlines" is a vexed one. For children of school age standards of intellectual functioning demanded tend to be higher than those accepted for adults. Among adults much depends on what Terman-Merrill or other mental age is accepted as a base from which to calculate an IQ. Whatever system is used the number of borderline cases will remain large, because no clear dividing lines between normality and subnormality are to be found.

Some comments on the medical classification by clinical type and on classification for educational purposes are made later in the report, but a word on the medical classification by grade is desirable. Emphasis in the past has been placed on lesions of the central nervous system. There may, however, be little relation between the importance of a pathological lesion and the severity of mental subnormality. In consequence, there has during recent years been more emphasis placed on physiological and biochemical aspects of function. It is possible that, in the future, classification will be able to be made on a rational and uniform basis which, though dependent on the nature of the disordered physical and psychological function, will be in conformity with pedagogic and social aspects.
3. Prevalence of Subnormality

Few attempts have been made to assess the prevalence of mental subnormality in different countries, and it is not possible to give definitive figures since prevalence rates depend on many factors which differ both with the society and with social and economic conditions. The proportions of children regarded as educationally subnormal in different countries vary greatly according to the criteria employed. Dutch estimates based on eight large cities give a mean rate of 2.6%; French estimates range from 1.5% to 8.6%, depending on age; English educational practice aims to make provision for 1% of schoolchildren in special schools, while a further 8% or 9% are considered to require special educational provision within the ordinary school system. Varying estimates have been given in different States of the USA and in Switzerland. For adults the prevalence rates are lower, and the recognition and even the manifestation of mild subnormality in adulthood is dependent mainly on thresholds of community tolerance and the complexity of social life, both of which fluctuate widely. Estimates are thus valid only for the time and place at which they are made.

It is, however, agreed by all that the number of mildly subnormal far exceeds that of more severe cases; and English statistics which have been widely quoted suggest that, among every 100 mentally subnormal persons, the following proportions will be found: 75 mild, 20 moderate, and 5 severe cases. In other words, the very great majority of the subnormal are of mild grade and potentially capable of being taught to make a fairly adequate social adaptation in appropriate circumstances.

The question whether the prevalence of mental subnormality is rising or falling is much debated. Advances in clinical and social medicine have in some cases reduced the incidence figures for certain clinical types of defect. The same advances have, however, served also to increase the survival rates of subnormal children who would formerly have died. On the other hand, remedial and social services have made it possible for some of these children to be taught to live lives which are at least partially self-supporting and sometimes wholly so. The greatest proportion of the subnormal, those for whom no organic basis is found and who are sometimes called residual or subcultural defectives, have been affected, along with the rest of the population, by the fall in the infantile death-rate which is a feature of nearly all 20th century societies. Several surveys have shown low but statistically significant negative correlations between the intelligence of adults, as measured by tests, and the number of children they have; and it is sometimes argued that, for this and other reasons, the incidence of subcultural subnormality must be rising. However, surveys carried out using intelligence tests in Scotland, England, and elsewhere
to test this hypothesis have failed to discover any decline in the level of intelligence. Hence, the question cannot be regarded as settled, since there are other complicating factors which make the interpretation of the results difficult. There is, at present, no direct evidence to confirm the hypothesis of an increasing prevalence of mild subnormality.

While prevalence rates generally valid for different societies cannot be stated, it must be recognized that the provision of services for the mentally subnormal must be determined to a very large extent by the overall numbers and prevalence rates found at any one time. Research into, and surveys of, prevalence rates should therefore be a continuing feature of the mental health programmes of individual countries. It should also be recognized, when planning services for children, that the more mild forms of mental subnormality are both more numerous and more difficult to detect than severe cases, and that mild cases are much more capable of social response.

4. Research and Fact-Finding

Despite the prevalence of and the high social cost imposed by mental subnormality, very little money is today being spent on research in this field. This is possibly due to the widely held idea that subnormality is not preventable and that, once it is diagnosed in an individual case, little or nothing can be done to improve the mental functioning of the patient. These beliefs are much too simple to be true and their persistence is an obstacle to progress. Even the small amount of research going on at the present time has shown that certain diseases sometimes causing mental subnormality can be controlled; and it is now well known that some of those who exhibit all the traditional signs of arrested or incomplete mental development can, by appropriate help (medical, educational, or social), improve their mental functioning. Further research in the future is likely to make possible (a) the prevention of many forms of subnormality, and (b) the improvement of some of those who are subnormal so that they may become less of a social and educational problem.

The need for further research into all aspects of subnormality is one that needs the strongest emphasis. Although in pathological cases the cerebral changes or malformations which result in mental defect are at present irreversible, research in the basic medical sciences can be expected to throw light on the causes of mental defect and enable the conditions to be brought under control. Research should be regarded as in a very real sense an investment which will in time result in an incalculable saving in social and monetary costs, and problems of research, prevention, and services must be considered together.
Some of the main aspects needing research are the following:

(1) Physiological and biochemical investigations into etiology and pathology; embryology; neuropathology and electrophysiology; genetics.

(2) Investigations into emotional, social, and educational aspects of etiology and pathology; individual and group psychotherapy; the prevention of delinquency.

(3) Methods of education, and of occupational and social training and guidance, which would ensure that full use could be made of remaining function.

(4) Prevalence studies of subnormality in different cultures and groups.

(5) Continued revaluation of existing services in relation to community needs, and the integration and development of services.

To carry out research into the main problems of mental subnormality, collaboration is needed among workers engaged in many different professions. Today the little research that is going on is, for the most part, being undertaken by individuals working largely in isolation from their colleagues in other professions. A consequence of this is that there is perhaps an over-emphasis on the genetic and other factors responsible for certain rare clinical conditions; very much more work is needed on nutrition and gestation and on social and psychological conditions and educational technique.

It must be pointed out that, in different countries, the main research needs may differ. As a general principle, the great social scourges—hookworm, syphilis, malaria, malnutrition, and the so-called tropical diseases in countries in which these are prevalent and in which mental defect or mental retardation may sometimes result as a serious aftermath—will have an obvious priority. Elsewhere, there are many areas in which the research needs in different countries overlap.

The committee draws the attention of governments and private foundations to the need for very much more financial aid to research. Fellowships and scholarships are required to make possible the training of research workers, and to stimulate practical as well as theoretical research in the universities, and theoretical as well as practical research in institutions. There must be interchange of ideas and staff between university and field workers, and collaboration among different professions. Without financial backing, research cannot be undertaken.

There is a great shortage of journals dealing mainly or entirely with mental subnormality. Only one scientific journal is known to be concerned entirely with this subject, which is usually neglected by journals concerned with general psychiatry. The literature is in consequence scattered, fragmentary, and difficult to obtain. While the committee is not able to
make positive recommendations to end this state of affairs, it none the less draws the attention of those concerned to its consequences, and urges workers in the field to endeavour by collective action to make the results of their work more readily available to their colleagues.

5. Prevention

In discussing the importance of prevention, the committee reviewed the major categories of causative factors producing mental subnormality. Such conditions can be described broadly under five main headings:

(a) Congenital conditions, including those determined by heredity (such as phenylpyruvic oligophrenia), those determined by the circumstances of pregnancy (such as maternal rubella, syphilis, and rhesus incompatibility), and those with unknown etiology (such as mongolism).

(b) Traumatic conditions due to birth or accident.

(c) Post-natal conditions resulting from diseases such as meningitis and encephalitis.

(d) No cause yet found—sometimes called the residual or subcultural group.

(e) Severe psychological retardation arising from deprivation of emotional needs in early childhood.

The committee considers that the distinction drawn by the Joint Expert Committee on the Physically Handicapped Child between the terms “primary” prevention and “secondary” prevention is a useful one. Primary prevention relates to measures which prevent the initial occurrence of the handicap—for example, the control of syphilis or rubella. Secondary prevention relates to early discovery, early diagnosis, and early and continuous care, so that the extent and impact of the disability will be mitigated as much as possible. A great part of the various social and educational services which are advocated in this report can be regarded as methods of secondary prevention, in that they aim to lessen the consequences of disability, and to enable children to make the most of limited abilities.

A matter which the committee considers very relevant to its terms of reference, and which is in need of more attention than has hitherto been paid to it, is the relation between emotional deprivation and mental subnormality. The question of maternal deprivation and mental health has been discussed elsewhere and the evidence as it affects the mentally subnormal will not be considered here. Four conclusions may, however, be noted:

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(1) Wherever it can be arranged, and appears to be not against the interests of the child and the family (including its normal children), those subnormal children for whom institutional care is not absolutely necessary should have provided for them and their families the economic and social conditions which would enable them to be kept at home.

(2) When foster-home placement has to be made there should be careful selection of the home and foster-parents, followed by intensive case-work, should this be needed to prevent the placement from being a failure.

(3) If it is found necessary to remove a child from his parents because they are not considered capable of looking after him properly, the situation of any other children in the family should be carefully investigated. It may, in many cases, be better to remove these children at once from the care of their parents than to leave them with unsuitable parents until they are older and have endured more years of neglect and misery.

(4) Whatever the decision considered best in the interests of the child and his family, transfers from one foster-home to another, or from foster-home to institution, should be kept to a minimum. One of the strongest reasons for keeping the child with his own parents is that once he is out of his own home he is lucky if he finds someone who will care for him until he is grown up. Even for good foster-homes the rate of replacement is high, and even in good institutions the turnover of staff is a constant problem. If, however, a young child must be removed from his home, he should be placed in a situation in which he has the opportunity to form a continuous attachment to a single adult. To do this may require much planning of an institution regimen, or skilled social case-work where the child is in a foster-home. These will be worth while if they enable successful placement to be continued.

Fortunately, it is not often necessary to take children from their homes; and with adequate economic aid to parents of handicapped children, skilled social case-work, and properly organized and comprehensive social services it will become less so.

6. Services

A. Infancy and Early Childhood

*Discovery and diagnosis*

Although some forms of mental subnormality, usually those of severe grade, are recognizable at birth, the majority of cases look much like normal children and are first distinguished by their slowness of development. During the period of infancy, only cases of fairly gross handicap
are likely to be diagnosed. In the pre-school years, however, it becomes possible to discover a good deal of moderate subnormality and some mild cases. Others are not suspected until they are of school age.

Because of our ignorance of the causes of much mental subnormality, it is easier to discover that a child may need special care because of slowness of development than to diagnose a clinical condition. And, except for a few rare clinical conditions which result in severe mental defect, neither discovery nor diagnosis can enable accurate predictions to be made as to the level of function which the infant will achieve in later life.

Data from a number of sources are needed to make the best appraisals of a child's total potentialities. Among these may be mentioned clinical signs, physical abnormalities, subnormality of development, and emotional disturbances. While, in some cases, clinical anatomical signs enable a diagnosis to be made, in the main an observed subnormality of function does little more than pose a problem for further investigation. This may require the collaboration of the physician, physiologist, biochemist, psychologist, and social case-worker.

Wherever there exist services which could enable help to be given to the parents and to a handicapped child, early discovery and diagnosis are to be aimed at, even though this may mean that some mistakes are made. To leave parents to struggle alone with the problems raised by a subnormal child, or to attempt to reassure them that the child is really normal or "will grow out of it", is not in the interests either of the child or the family, or of society. Even those countries which have made fairly adequate provision for children of school age have usually failed to appreciate the importance of early diagnosis and the need to make available adequate and flexible provision for children in infancy and early childhood. The matter will in consequence be further considered here, although discussion of services and the development of programmes as a whole is taken up in section 10 (see page 41).

If early discovery and, where possible, diagnosis are to be aimed at, three further problems must be considered: referral of cases and collaboration of specialists, advice to parents, and disposal.

First, referral. Some severe cases, especially those with obvious physical abnormalities, and the majority of mongols, are discoverable at birth, and the doctor or midwife who delivers the child should know to whom to report the case and what action to take. In some cases of older infants or young children, the first person to be consulted or to observe that the child's development is not normal may be the family doctor; in others, it may be the public-health nurse (health visitor). Similar observations may be made at a child welfare clinic or nursery school, or by a social
welfare agency or friend or counsellor. The public-health nurse has a particularly important role to play. She is likely to be one of the first specialists appointed to a newly established maternal and child health service and may be the only person in the district to whom the parents can turn for advice. She must therefore be trained to observe the signs of subnormality, and must be able to give advice on the medical, psychological, and social aspects of the problem. Where more elaborate services are available some of these duties may be the responsibility of others, especially the family physician, but upon the public-health nurse will still remain many of the responsibilities for giving advice on day-to-day problems.

What happens once a condition of subnormality is suspected must depend on the services available. Wherever it is possible to do so, the case should be referred to a specialist, or team of specialists, who will examine and observe the child in different situations and from different points of view and make an assessment of its condition. The required experts are likely to be most readily available in the psychiatric unit of a paediatric department of a general hospital, in a child guidance clinic, or in the outpatient department of a mental deficiency hospital that has provision for infants and children.

Diagnosis or discovery is, however, not an end in itself. Indeed, there is little point in establishing a diagnosis, except to draw the attention of the authorities to the existence of the problem of mental subnormality, if nothing more can be done to help the family. But even in poorly developed countries there is usually some advice that could be given. As the level of the public-health, social, and educational services rises, so the amount that could be done increases. In highly developed countries comprehensive services can be organized.

What advice is given to parents and who is to give it are matters that can best be decided in a case conference in which all the specialists concerned take part. Two aspects must be distinguished: therapeutic discussion with the parents, and advice on planning for the care of the child, whether or not he remains with the family.

The discovery that a child is subnormal will inevitably come as a profound shock to parents. In many cases they will feel a groundless personal guilt or will, half-consciously, blame their marriage partner for the child's condition. They may need the opportunity for frank discussions with a specialist in both the field of mental subnormality and of mental health. It need hardly be added that more than one discussion may be necessary, since the parents cannot be expected to understand and face the full consequences of matters of such strong emotional significance after a single interview. At the same time, they should be given accurate information and have their questions fully and frankly answered.
In addition to therapeutic discussions, continued if need be from time to time over a period of years, parents need advice on how best to treat their children. Subnormal children present problems of upbringing not found in normal children, and parents must be advised how to cope with these. They should also be told what they can expect of the child, and be helped to guard against demanding either too much or too little.

Once a diagnosis has been arrived at, a major decision which has to be taken is whether the child can be cared for at home or should be placed in an institution or foster-home. This decision need not be taken at once, and it may happen that a child can be cared for at home in early childhood even though when older he will need institutional care. In different countries opinions regarding the desirability of placing subnormal children in institutions will naturally differ according to the prevailing social philosophy and the facilities available. In some societies with strong traditions, families are not willing to give up their weak or old members to the care of others, and regard the segregation of the mentally handicapped as callous and inhuman. In Western society, as families have shrunk in size and institutional provision has become more readily available, there has been a tendency to recommend the placement of all severe cases and a number of cases of moderate subnormality in institutions. It should, perhaps, be added that, although to some parents in some societies institutional placement may be the most easily acceptable solution of a difficult problem, the general principle applies here that the mental health of the community as a whole will not be necessarily improved by the mere segregation of the abnormal, whether they be subnormal, senile, physically handicapped, or psychotic.

The committee was of the opinion that, in coming to the decision to recommend institutional placement, three aspects should be considered: the actual condition of the child; the mental health of the family, the competence of the mother, and the possible effect on the family of retaining a subnormal child in its midst; and the living conditions and financial circumstances of the family. In the discussion of the decision to be taken it would seem essential that the family doctor or the public-health nurse concerned with the case should take an active part.

As a general rule, home care is to be recommended, unless the subnormality is very severe or the retention of the child in the home is likely to bring about serious maladjustment or the dislocation of other aspects of family life. Even children who are severely subnormal may be kept at home if the parents are able to take a realistic view of the situation and if they are able to make full use of comprehensive maternal and child health services. Moreover, generous financial and practical assistance to parents is still cheaper than hospital care, a point not often realized.
The committee does not look with favour on the growing practice of very early institutionalization. In many instances the parents are advised not to take the child home from the maternity hospital, a decision which constitutes a real hazard to the mental health of the family unit. It must be remembered that parents make a heavy emotional investment in all pregnancies and when an abnormality occurs they invariably experience feelings of guilt. The immediate admission of the infant to an institution not only fails to relieve the stress but may even intensify it. The placement is likely to be interpreted by the troubled parents as a confirmation of their own feelings of guilt and an irrevocable rejection of the child. No institution can provide an adequate substitute for the essential emotional interaction between parents and child, and this opportunity for interplay is of paramount importance in the case of the handicapped child whose parents can only slowly evolve a realistic and constructive attitude towards the situation. As a matter of fact, there are many instances of defective children being accepted by and thriving with their families. It can be denied categorically that all such infants should be institutionalized at once. In each instance the decision concerning the proper time for such placement must be made on the basis of the psychological needs of each individual family constellation.

Provision for subnormal children living at home

Although in favourable circumstances some of the grossly subnormal can continue to be cared for at home, at least when young, the majority of cases remaining in the care of the family will be children of mild and moderate subnormality. For these children some specialist follow-up services may be required. But in most cases, especially during infancy and early childhood, much of the supervision of the general development of the child can continue to be exercised through the maternal and child health services. The home visits of the public-health nurse are particularly important in enabling continuity of supervision to be achieved. Her knowledge should be supplemented by advice and assistance of the social case-worker.

A point of importance is the provision of domestic and financial help to parents needing it, or during times of sickness or holiday, so that they will be able to continue the home care of the child when this seems the best course to take. It should be possible for a parent to place a subnormal child temporarily in an institution, if domestic assistance cannot be obtained at a time of crisis. A factor in favour of home care is that normal children living in the same family can be of great assistance in promoting the development of a subnormal child, if home conditions are good.
Provision of nursery-school education for the mentally subnormal

Nearly every country in Europe now has nursery schools for a proportion of its children, and in the so-called underdeveloped countries very considerable developments have been or are taking place. The nursery-school teacher sees the child with other children and therefore can observe the comparative development from the age of 2-3 years onwards better than anyone else. Not infrequently, nursery schools precede child welfare services, and where this happens they must be made full use of.

Today young mentally subnormal children are sometimes excluded from nursery schools where these exist and could take them. This may be necessary in cases complicated by psychosis, or by physical or behavioural peculiarities which make it impracticable or undesirable that the child should associate with normal children. In many cases, however, there is no reason why a young child of mild subnormality should not play with normal children of about the same physical age.

While, therefore, under certain circumstances it may be necessary to have nursery schools taking only subnormal children, the most favourable type of nursery school provision is that in which a few subnormal children are included in a larger group of normal children.

Residential care

However adequate the services for home care may be, there will still be a need for institutions to provide for the needs of many of the severely handicapped and some children with lesser handicaps. An alternative form of provision for some of these children is the foster-home. In general, the availability of foster-homes for all types of placement has not been fully explored in many countries.

Elsewhere in the report the major problems relating to institutional care are touched upon. In relation to the specific needs of young children, certain guiding principles should be stressed.

Institutional care has to offer a substitute for home and parents to a child wholly dependent on others for his needs. Besides having facilities for meeting the physical needs of the children, the institution should be organized so as to provide for their emotional and social needs. In practice this means that institutions should be small or divided into small units, and that for the infant and the pre-school child there should be a large number of well-trained staff who should have individual and continuing responsibility for a few children.

B. Mentally Subnormal Children of School Age

The education of all children, both normal and subnormal, should be the responsibility of the educational authorities; and no artificial barriers
should be erected between normal children and those for whom special provision has to be made. While classification into particular groups may be administratively and educationally necessary, the borderlines between groups, however drawn, are arbitrary, and rigid classification may do harm to many children. Children change in the course of development, and their needs and potentialities change. Hence, educational provision for the subnormal should be continuous with that for normal children and highly flexible in its organization. It should permit of easy transfer from one type of school or class to another.

The proportion of children in any community who are considered sufficiently subnormal to need special educational provision is to some extent a reflection of the structure and demands of the public educational system. Where education is competitive and academic standards are set up to which all children have to conform, failure is more conspicuous and damaging to the child than where curriculum and methods are child-centred and free of imposed standards. Again, the dull child in a small class is able to receive more of the individual attention he needs than is possible if he finds himself in a group of 40 or even 50 of his fellows.

Special methods, modified curricula, and a much greater degree than usual of personal attention from the teacher are necessary if subnormal children are to make the most of a limited capacity. Few but the most gifted teachers are equally good at teaching children of widely differing levels of mental maturity. Some degree of specialization of teaching and teacher is therefore also desirable; it becomes increasingly so among older children, since the range of individual differences increases with age.

Many countries with developed systems of education make provision in special schools and classes for between 1% and 2% of children of school age; some provide, through classes in ordinary schools, modified curricula for a further 5%-10%. In no country as yet is the present provision regarded as adequate in all respects; and a number, while offering special classes in sufficient numbers, provide no special education at all for the large group of children who are markedly duller than the average but not, in a technical sense, educationally subnormal.

The committee calls attention to children with dull normal intelligence who in general will follow the ordinary school classes, but who may have difficulties in adapting themselves to this teaching, particularly beyond the first period of their education. If this is not discovered, they may experience accumulating failure because demands are made which are beyond their capacity to fulfil. Some may at first escape notice by concentrating upon rote memorizing, and even at the end of the school-year tests may be insufficient to detect them soon enough to direct them towards a simplified curriculum more in accordance with their real needs. Thus, it is essential
that the diagnostic services should collaborate with the school in a realistic appraisal of such children's ability to adapt to education.

Probably the single factor which most militates against satisfactory education of the subnormal is the large class. The duller the child, the more need he has of individual help. Few public education systems have classes for normal children of less than 30; many have much higher numbers than that. The dull child is lost in a group of more than 15-20. For those who are moderately or severely subnormal the group should be much smaller.

For subnormal children, considerable modification of the ordinary curriculum is also necessary. This should not, however, simply take the form of watering-down the work done in ordinary classes, but should be based upon a close appraisal of the learning capacity of each child and of his need of experiences which promote his physical, intellectual, emotional, and social development. Attempts have been made to base curricula on an analysis of the skills required by children and grown-ups in a modern society. This is a realistic approach; but while a child should be trained, for example, to give and receive change, and to read and understand simple instructions and the like, an education consisting solely of these utilitarian habits is incomplete. Even the mentally subnormal are capable of a delight in creative activities undertaken for their own sake; the inclusion in the curriculum of music, crafts, drawing, painting, and discussion of the society in which the child lives is, for the majority, not a sentimental luxury but an essential aspect of their education.

The length and planning of the school-day need not follow the normal practice of ordinary schools. On the one hand, many subnormal children have poor physique and tire easily; others suffer from sensory, motor, and physical handicaps which require a modification in the demands made upon them. They find it very difficult to fix their concentration upon tasks which may seem to them to have very little real meaning, such as some early instruction in reading, although they do give their attention for long periods to activities, especially social activities, in which they are interested. It may be desirable, therefore, to have a rather shorter school-day than that of ordinary schools, with periods of instruction, play, and social learning of differing lengths.

In some countries a clear distinction is made between formal instruction in school subjects and activities leading to social and personal development. Other countries do not accept this distinction, because they hold that the learning of formal skills, such as those of reading and arithmetic, takes place most effectively in situations of a social and practical kind where the reasons for them are more apparent to the child. In countries of the first type, it is usual for the teacher to give instruction, while the more general activities either are the responsibility of the parents or are assigned to other persons
who should be specially trained to carry them out. In countries which follow the second course, the teacher is expected to combine the two functions. However the matter is arranged, it is essential that both aspects of development should be fostered.

The more limited the child's scholastic ability is seen to be, the more important becomes that aspect of his education devoted to his personal development and social adaptation.

From what has been said it is clear that different and, in some respects, heavier demands are made upon the teachers of subnormal children than on their colleagues elsewhere in the educational system. They need insight, a high degree of personal maturity, and a special competence developed by training in order to discharge their duties satisfactorily. In many educational systems, however, the teacher of subnormal children considers himself shut off or banished from the normal schools; his opportunities of promotion may be affected; and his salary may even be lower. The committee wishes to underline the fact that the education of subnormal children is more exacting than teaching generally, and that the special nature of the task should be adequately recognized.

The organization of educational provision

Countries which have developed special facilities for subnormal children of school age have found that great variety is needed. This variety is determined by educational considerations such as those outlined above, by social attitudes within communities, and by economic and geographical factors. There are, however, three principles which should be observed when developing any scheme. Unless a child is so gravely subnormal as to be completely incapable, his education should be the responsibility of the public education authority, even though the child is in fact in a hospital or medical institution. Secondly, no matter what the degree of his defect, a specially adapted education should be provided for him as well as the social, medical, and other services essential to enable him to profit from it. Thirdly, every effort should be directed to prevent his being cut off, by the special provision made for him, from his family, from other more normal children of his own age, and from the community in general.

In areas which are fairly closely populated, many of the mildly subnormal and dull children can be educated by special arrangements or in special classes in ordinary day-schools. The teachers should be capable of modifying method and curricula to meet individual needs, and the class should be adequately provided with material and apparatus. For many school activities the children in these classes can mingle with their able fellows on terms of equality. If properly handled, this facilitates the later acceptance of the subnormal adult in society and his adaptation to it. It is also easier to transfer children to and from the special class.
For the unstable and more markedly subnormal pupils, necessary modifications of curriculum, method, and organization of the school-day are such as to make more difficult the integration of the special class into the ordinary school. Some countries have, therefore, in urban centres, special day-schools grouping upwards of 100 children and conforming more or less to the usual school terms and hours, though with alterations to meet particular needs. Such a concentration makes easier and more practicable the provision of the special services which may be needed—for example, speech therapy, physiotherapy, medical care, social work, and special transport arrangements for those children who cannot safely get themselves to and from home. The special day-school also provides a more congenial atmosphere, where personal consideration for the emotional and social needs of children can be emphasized, than is easily to be secured in a single special class conducted in connexion with an ordinary school. It also allows for the extension of the school-day to include the less formal, but no less important, aspects of the child’s out-of-class life. In large centres of population where more than one such school is necessary, some degree of specialization also becomes possible from one to another.

A modification of the special day-school is the day-boarding school, which has been tried with success in a number of countries. In these schools the children pass a large proportion of their waking time. They sometimes have breakfast, midday meal, and a rest period at the school, and return home only at night and at week-ends. Within such a lengthened day it is easy to provide many of the medical and allied services that may be necessary in individual cases, and to include a great deal of education of a less formal kind than that of the normal classroom activities.

It is only in urban areas with a considerable density of population that the organization of special day-schools and classes is possible. In rural districts and in predominantly agricultural countries there may be a need for full-boarding special schools. There is too a group of children, even in urban areas, for whom, because of physical or emotional handicaps, or the inadequacy or absence of their family, or some other reason, a boarding-school or a fully residential institution is necessary. Where boarding-schools are set up for subnormal children certain essential psychological criteria should be observed.

The child’s out-of-class life should allow him to develop and maintain a close contact with one adult, and he should live in a group as nearly reproducing the atmosphere of the family as possible. The younger and duller the child, in general, the more necessary this is. Where the child has a satisfactory family of his own, he should, where at all possible, return to it for holidays, and the school should, either directly or through visiting staff, maintain a close contact with the home, helping the parents to accept the child’s mental limitations and satisfy his developmental needs. Where
the child has no home or family, every effort should be made to find him a foster-home to which he can return in his vacations. Children who, for medical or social reasons, have to spend their whole time in a residential institution stand in even greater need of a substitute family and every organizational means should be taken to ensure that they have it.

In the special boarding-school arises the question of whether the teaching staff should be different from those who look after the child in his out-of-class hours, thus preserving the dual psychological worlds of school and home, or whether the teacher should also form part of the child's substitute family. No hard and fast recommendation can be made, and each country in this as, for example, in the question of whether such schools should be co-educational, will develop its practice in accordance with the traditions of its teaching profession and its own customs.

The residential school for subnormal children should be relatively small but large enough to allow a sufficient number of teaching staff of both sexes to have among them a variety of experience and skills. Experience suggests such schools should cater for between 60 and 120 pupils. This requires some five to eight teachers, as well as the non-teaching staff necessary for the daily life of the children. Such schools should be provided and maintained by the education authorities, even though in some instances they may be closely associated with, and even operate within, a medical institution.

A word should be said about the length of the educational period for subnormal children. They develop more slowly socially and educationally than brighter children. Hence, they do not keep in step with their fellows and the usual ages of transition from one form of education to another (i.e., from nursery- or infant-school to primary school, or from primary to secondary education) may not be appropriate. Where some form of separate special school provision exists, difficulties do not normally arise; where, however, the dull child is in a school for ordinary children, it may be desirable to point out that chronological age criteria for passing from class to class, or from school to school, should not be rigidly applied to them. The extension of the period of schooling beyond the age limit of compulsory school attendance by normal children by at least one year and preferably more should also be considered.

*Children with moderate and severe handicaps*

In educational practice, a clear distinction is often drawn between children with mild subnormality who are educated in ordinary schools or special schools in which they learn reading, writing, and arithmetic, and participate in other school activities, and children who cannot satisfactorily
acquire the basic educational skills. These children are often called "in-
educable", although the term "trainable" has been suggested as an
alternative and this term is preferred by the committee.

The terms "educable" and "trainable" have some practical value in
differentiating between the intellectual capacities of children of school age.
But there are real difficulties in attempting to differentiate education from
mere training. Characteristics of training which are sometimes assumed
to be specific to it, such as emphasis on the learning of habits in concrete
situations, or on the development of ability to speak with purpose and to
receive instruction by word of mouth, apply in fact to a true education.
All the criteria of trainability we have examined, we find apply also to
educability.

There are, nevertheless, real differences in practice between the pro-
grammes suitable for moderately or severely handicapped children and the
curriculum of a special class or school. Four main differences were noted
by the committee.

(1) The greater the degree of subnormality, the less emphasis will be
given to long-term educational objectives. In dealing with the fairly severely
handicapped, results must be sought for in very small improvements in
behaviour, skill, and social adaptation.

(2) The more subnormal the children, the more mechanically they may
have to be taught skills and habits, and the less insight they may have into
the purpose of learning.

(3) The teacher of children with moderate or severe handicaps will be
less concerned with training or education for future independence, or for
life in a fairly wide community.

(4) Skills and habits involving symbols of reading or arithmetic may
be excluded.

The committee wishes to emphasize that, even among the severely
subnormal, the number of children of school age who cannot gain some
advantage from education of a very simplified form is extremely small. The
education authorities should therefore have the responsibility for providing
suitable education to all children of school age. Today it is common to
find so-called ineducable children excluded from the educational system.
They may be either housed in institutions in which they are given little or
no education, or left unprovided for at home. They need, on the contrary,
a very special form of education, with an adequate staff. In a day-centre
of 25 to 50 such children, there should be a supervisor, at least two assistant
supervisors, an attendant, and a cook. The supervisor and assistant super-
visors should be specially trained and should be recognized as part of the
general teaching service.
The education of subnormal children is a difficult and delicate task in which the teacher needs the fullest support from the social, psychological, and medical services, working as an integrated team. It is insufficient to give a diagnosis and provide intermittent help to the family and some casual advice on method to the teacher. The school health and psychological services, particularly, have a continuing part to play in the education of the children in special schools and classes. Too often, child guidance clinics are content to diagnose mental subnormality and then to repudiate further responsibility. The child psychiatrist and the educational psychologist have, however, more than diagnosis to contribute; and if they are well trained they can be valuable helpers of the specialized teacher, especially in enabling him to develop steadily more adequate methods and in undertaking remedial psychological work with the more disturbed children.

Teacher, social worker, psychologist, medical officer, and public-health nurse have, too, roles to play in the education of parents and of public opinion. Every special school or class should have its parent-group in which, by discussion, short talks, films, and activities which contribute to the welfare of the school, all those who deal with subnormal children may come better to understand each other and to co-operate in their joint task.

C. Adolescents and Young Adults

Mental subnormality and employment

The criteria for judging mental subnormality in adult life are to a large extent based on social and occupational competence. It is obvious that these are functions of the kind of society in which an individual lives. If there is widespread and prolonged unemployment, then not only will the subnormal and the dull, the physically handicapped, the neurotic, the middle-aged, and the old find it difficult to obtain work, but young and fit adults will likewise be affected. In times of economic depression, unemployment is an added complication to their lives. If unemployment were to be regarded as a normal feature of industrial life, the outlook for many dull and subnormal adults would be a bleak one. But chronic unemployment need not be, and is not, a feature of all industrial societies; and a comprehensive health service cannot be put into operation if the well-being of the members of a society is not also protected in a basic, economic way. It is significant that, whereas pre-war studies emphasized the social incompetence of the subnormal, post-war studies have shown that, if there are jobs available and the necessary assistance is given, the majority of those whose subnormality is mild will be able to find work and keep their jobs successfully. The incidence of occupational maladjustment among the subnormal is, however, likely to be higher than among the normal, and
special guidance and training are desirable. It is easier to arrange these if adequate social services are available for all young people.

_Vocational guidance_

Vocational guidance should be available for all subnormal school-leavers, since adolescence is the period in which job difficulties are most frequent. The first step must be a study of the kinds of employment available in the district. This can best be done by the department of labour or its equivalent. Economic analysis needs to be supplemented by job analyses—or at least job inspections—to see the conditions of work in different occupations and industries, and the demands which the work makes on the workers. Only on this basis can efficient guidance be given. Too often in the past vocational guidance officers have been ignorant of the kinds of work in the community that could be done by subnormal adolescents; and occupational psychologists in particular have devoted too little time to field work and empirical investigation of the labour market.

Many of the current assumptions about the abilities and potentialities of the subnormal have been made on a priori grounds and without much attempt to validate them. One result of this, and of the outmoded idea that disabled adolescents and adults are fit only for certain limited and menial jobs, has been that the subnormal have been placed in too few types of work—notably domestic service for girls, and unskilled work in hotels and farms for boys—and little attempt has been made to explore the possibilities and suitability of other kinds of employment.

There are, in fact, many occupations in an industrial society which subnormal individuals, properly and carefully placed, can perform. A lead has been provided in the Netherlands, where a comprehensive analysis has been made of all types of job available in Holland which are suitable for the subnormal, as well as for normal and bright adolescents and adults. The US Employment Service has carried out similar investigations and more modest surveys have been made in other countries. These examples should be more widely followed. Job analyses and classifications cannot be merely taken over from one country to another, and in each country research departments, preferably in association with the universities, should work closely with the departments of labour or youth employment services to provide for vocational counsellors accurate and up-to-date information on employment for the mentally subnormal. This knowledge should be constantly checked and revalued in the light of changing conditions.

Experience from several countries underlines the desirability of making vocational guidance the outgrowth of sound educational guidance and thus a continuing process beginning well before the child leaves school. With
this end in view, cumulative school records should be made by class teachers of each child's progress over several years. To be useful, these must be carefully designed in such a way that they will suggest answers to certain specific questions; mere records collected with no particular object in mind are often not worth the time they take to prepare. Class teachers, too, should be encouraged to think of the child in relation to his future job. They cannot evade this responsibility by simply considering the child as "unemployable". If they are kept informed of the follow-up studies carried out on those whom they have taught in the past, and are asked to play a part in the vocational guidance conferences which concern children whom they know, they are less likely to forget that the future of the children whom they teach has to be considered, and that they have an important part in moulding it.

In other ways vocational guidance should begin early in an adolescent's career. Formal and informal consultation between the teaching staff, parents, and youth-employment and vocational-guidance officers should begin well before an adolescent leaves school. In the past, too little attention has often been paid to the parents: recent research has indicated that, where they are consulted and are convinced of the value and sincerity of the vocational-guidance and employment services for young people—both normal and subnormal—and can be persuaded to carry out the decisions arrived at, guidance is much more successful.

Adolescents in institutions or without parents have special problems which must be considered. The institution authorities should not be left to solve their problems of vocational guidance and employment on their own. On the contrary, special efforts must be made to create links between those who care for the subnormal in the institution and those who deal with their problems in the vocational-guidance and youth-employment services.

If adequate school records are available to the vocational-guidance or youth-employment authorities, most adolescents who come to vocational guidance centres should not need further psychological testing. Personality inventories and special aptitude tests may be an adjunct to, but are not a substitute for, the vocational-guidance case conference in which all who have responsibilities towards the child pool their knowledge. Psychological testing services should, however, be available for dealing with children who present special difficulties, or who may be thought to have special qualifications or abilities. In short, in guidance centres there must be close collaboration between the school and the youth employment services, and guidance should be given by those who know the labour market thoroughly and have a realistic knowledge of the potentialities of the subnormal and the demands made by different kinds of work.
Guidance to the subnormal can best be given within the framework of vocational guidance centres for normal youth. The recommendations of the International Labour Conference concerning vocational guidance offer a guide to the vocational guidance services needed and include reference to the needs of special groups such as the subnormal.

For the subnormal with special handicaps, placement should be carefully made with employers and work-people whose sympathies can be enlisted to help the handicapped adolescent. In these cases, individual attention and follow-up by a trained social worker or vocational counsellor are essential. Since most of the difficulties which young people meet come at the beginning of their work career, when they are faced with a bewildering and complex situation which their previous life-history can hardly have prepared them to meet, counselling is particularly necessary during the first few weeks and months of their working life. Difficulties which would become insuperable, if allowed to mount up, are easy to deal with if observed and straightened out when they first appear. But they can only be dealt with by trained workers who have won the confidence of the child, and who have a knowledge of the work situation and the family. Parents as well as the young person himself may need advice and help, for the parents’ role is of decisive importance.

Whereas stable adolescents of subnormal intelligence may usually be expected to be able to work for a full day’s wage, the unstable or weak, or those who are unrealistic in their ambitions or unable to do a full day’s work, may need to be employed on a reduced wage. Wherever possible, however, the full wage should be paid.

Vocational training

Many subnormal adolescents may be too immature to enter employment at the normal school-leaving age. For these, additional schooling or training should be available. This should be thought of as education with an increasing vocational bias. A possible compromise between school and work is the "training workshop", especially for adolescents in cities and towns who will be employed on industrial work. In a training workshop of this kind they can be taught habits of work, the need for punctuality and for steady work, and so on. By being paid for their work they can learn the value of money, what it can buy, and how to look after it. Some kind of promotion scheme within the training workshop is desirable, to bring home to them that it is by their own efforts that they will succeed in the community. There might, for example, be different kinds of work done there, with different amounts of pay given for each. Promotion from one job to another should depend on criteria known to and understood by the young person himself. In training workshops normal industrial work
should be undertaken if this can be arranged, preferably work of the same kind as the adolescents are likely to be employed on in the community. The workshops could form the senior departments of special boarding- or day-schools. This would avoid the need to transfer these young persons to new surroundings during the unstable period of puberty. At the same time, transfer to a separate workshop would have the advantage of stimulating them to a new level of adjustment. When they had received sufficient training, the young persons should be placed at work in the community whenever practicable, and given careful supervision.

It is important to differentiate between training workshops and sheltered workshops. Too often those who could, with practice and experience, learn to work as normal workers are over-protected in sheltered workshops and, in this way, are actually incapacitated from later taking their place as normal workers. This kind of over-protection has been common in the services which have grown up for all kinds of handicapped workers.

It should be emphasized that even repeated failure over a course of several years may not necessarily mean that a subnormal adolescent is fit only for sheltered employment or residential care. Adolescence is often protracted in the subnormal, and the vocational counsellor should be aware of changes in attitude which might make the chance of successful employment greater.

The committee considered the alternatives of specific training for a particular job and a more general training which might enable an adolescent to take one of a number of jobs. It was generally agreed that, if the subnormal were placed in simple and unskilled work, specific job-training could, in most cases, be obtained fairly quickly on the job. Hence, in the training workshop, a general training in habits of work and an understanding of the general industrial environment should be emphasized. These habits of work cannot, however, be so easily inculcated if adolescents are trained to meet the needs of an age which has already passed, for example, if they are trained to do craft work demanding great precision rather than speed, but are expected later to do routine repetitive work in which speed is essential, or if they learn to do by hand jobs they will have to do by machine.

The recommendation that the bulk of vocational training should be general rather than specific follows on from and supports the earlier recommendation that, during the period of school age, the child should also have an education which is general rather than narrowly vocational. This will make possible the development of a stable and relatively mature personality, resilient and able to withstand the exigencies of adult life in society.
Even adolescents with comparatively severe subnormality can often be employed on simple work. Many cannot do a full day's work, but part-time employment with a sympathetic employer on personal and friendly terms is the situation in which they may be happiest. If such employment is not available, it may be necessary to set up sheltered workshops for them. In these they should be able to do useful work, although occupational therapy can also be done. Doing useful work for which they are paid, even if only small sums, gives them great satisfaction, and makes them feel they have a real place as adults in the community. Useful work should be recommended wherever it is practicable, and occupational therapy should be confined to the lowest grades, the most severely handicapped among the physically crippled, the disturbed, and the psychotic.

The recommendations made so far apply more to urban than to rural adolescents. Hitherto, the needs of rural adolescents have received little attention and there is need for much more study of the jobs available in rural areas and how training can best be carried out. While much has been done to train and successfully place subnormal individuals of both sexes as agricultural workers, and to find suitable domestic jobs for girls in rural areas, there has been little research into alternative methods of training and other avenues of employment. Systematic study in which many community agencies are involved can hardly fail to suggest more efficient and valuable methods of guidance and training.

Social problems of subnormal adolescents

Attention has been drawn to vocational problems which arise with adolescents who are mentally subnormal. These have been frequently overlooked or inadequately dealt with in many countries which have developed programmes for the subnormal. There are, however, other social problems of a more general nature and the subnormal adolescent needs assistance in meeting these. Assistance can best be given by trained and experienced social workers.

Among the forms which assistance to or supervision of the mentally subnormal may take are:

1. Explanation of his limitations and potentialities, both in work and in personal and social behaviour, which may need to be given to his family, workmates, or acquaintances.

2. Assistance in securing board and lodging away from his family in some cases. The arrangements made should take into consideration not only the physical adequacy of the quarters, but also the emotional atmosphere of the home and the social characteristics of the neighbourhood.
(3) Arrangements to enable the subnormal adolescent to enjoy the social life of the working group outside working hours. In view of the fact that assistance for the subnormal in planning social activities and recreation has been grossly neglected, it seems well to focus some attention upon this matter. Some of the characteristics common to mentally subnormal individuals make it difficult for them to integrate easily into a normal social group, since they are frequently lacking in verbal ability, resourcefulness, judgement, co-ordination, and physical skills. They are more likely to be followers than leaders, and may need direction in planning their leisure activities.

It is only recently that recreation has been recognized as a basic human need, which can give refreshment to body, mind, and spirit. It is important to recognize the need of an individual for group membership or "belongingness"; society should allow every individual an opportunity to adjust to a group. Clubs, whether of a social, educational, athletic, or religious nature, can provide valuable services for the mentally subnormal. Among some of the opportunities they can offer are:

(a) provision of education in recreational skills or "know how";
(b) the formation of friendly relationships;
(c) the development of a greater ability to get along with other people; and
(d) the opportunity to carry responsibilities and to perform reliably the functions delegated to them.

Clubs for recreation or leisure-time activities can do much to help the individual to become happy and well adjusted, thereby providing part of the atmosphere which will contribute to both vocational success and worthwhile community living.

(4) Assistance in the handling of his money.

(5) Assistance in making friends and in finding adequate leisure-time activities. This is particularly important, and may be very difficult. Loneliness or bad companionship is responsible for a great deal of the maladjustment or antisocial conduct among the subnormal, and much thought and experimentation are needed to evolve in different societies appropriate personal and group activities in which subnormal adolescents may participate.

(6) Assistance in forming wholesome boy-girl relationships, and in securing the co-operation of other agencies in preparing the individual for the responsibilities of marriage.

(7) Protection of both the individual and the community in cases of delinquency or charges of delinquency. The mentally subnormal need
protection in such situations, so that their mere subnormality may not be used as a cause for unjust charges and lack of proper legal services.

(8) Provision of proper legal services for the protection of the mentally subnormal in all cases of court action involving delinquency, settlement of estates, divorce actions, support actions, and cases involving custody of children.

The recommendation for complete and continuing social services for the mentally subnormal is founded upon the need for careful and intensive supervision, with case-work directed towards preventive services as well as rehabilitative ones, and with the utilization of all resources within a community which will assist in the development of a healthy personality. To be effective, a social worker must be able to see her charges frequently; small case-loads are therefore necessary. There is, however, little doubt that the employment of an adequate number of trained social workers to deal with problems of mental subnormality would be an economic as well as a humanitarian step forward.

D. Institutional Provision

If a subnormal child cannot be cared for or properly educated while living in his own home, he must be looked after somewhere else. Institutions of various kinds are thus necessary. They include the foster-home, the residential school, the boarding-home for adolescents, and the hospital or institution proper. Wherever possible (e.g., for the mildly subnormal, who can be placed in foster-homes, and for adolescents, who can live in boarding-homes), small units are to be preferred. But for some cases hospital care is more appropriate. The committee could lay down no general rule regarding the optimum size of hospitals, since much depends on geographical factors and the density of the population. Some guiding principles regarding institutions can, however, be given.

An institution should provide as far as possible the conditions which allow children full development, physically, emotionally, and intellectually. They should be divided into small units in which there are sufficient staff to enable the children to have satisfactory parental substitutes.

Where this is possible, institutions should be located in or close to urban areas and near medical and other centres from which technical and specialist advice can be obtained.

They should be within easy travelling distance of the community whose needs they serve. Every effort should be made to provide the transport and facilities which will enable parents to visit their children, and they
should be encouraged and helped, where necessary, to do so. Institutions in remote parts of the country have difficulties in maintaining contacts with the home and with welfare agencies.

The patients in the institutions must be classified and divided in such a way that some units care for the mildly subnormal, while others take the moderately and severely handicapped. Children and adults should also be separated, although subnormal women might sometimes assist in caring at least for those subnormal children who are not expected to achieve eventual independence in the community. (This is a matter on which further research is needed.)

Hospitals for the subnormal should be centres for research and teaching, and should be places in which the training of professional staff can be carried out. They should also provide many of the specialist personnel for work in the community; the community services for the subnormal should be arranged in such a way that this becomes possible.

In small institutions, a large part of the staff's time could well be spent in outpatient work, and in general the professional staff in all hospitals should be sufficiently numerous to provide necessary specialist advice on a sessional or part-time basis to outpatient clinics in other hospitals, child guidance centres, and vocational and other specialized centres.

The conditions of those who work in institutions in most parts of the world have long been in need of review. In many cases hours are too long, pay is too little, and living conditions are too unsatisfactory to attract and retain good staff. Workers engaged in the various professions associated with the care of subnormal children in institutions need good conditions, with opportunities for study-leave and adequate holidays, good pay, and the possibility of living a normal personal, family, and social life. Everything should be done to build up a permanent, long-service staff, particularly of nurses. Failure to provide good conditions in the past in some countries is now resulting in serious staff shortages, which have a very bad effect both on the children and on the staff themselves.

7. Training of Personnel

To deal with the problems of mental subnormality workers in various community services have to be called upon. Physicians have in the past been key persons; they have been consulted because of their knowledge of clinical medicine. It is, however, clear that they cannot by themselves solve the problems of caring for mentally subnormal children and of looking after their needs. Only the combined efforts of the medical profession (including allied personnel), and of teachers, social workers,
psychologists, public-health nurses, and other specialists in the social, educational, occupational, and community services, working in close co-operation, can adequately deal with the problem.

Adequate training of those who will be concerned with the problem can assist the successful integration of the various specialties. Some aspects of training, both of the various specialists concerned with problems of subnormality and of others whose work brings them into contact with these problems, are therefore discussed and some recommendations of a general character are made:

(1) Those who work on a full-time basis with the mentally subnormal need first a general grounding in the basic elements of their profession. Early specialization is not desirable, since it leads to too narrow a view of the work. The amount of knowledge of problems of maternal and child health, mental health, education, or vocational guidance work will vary according to the profession of the worker. The doctor will, of course, be first qualified as such, and the psychiatrist will have a knowledge of general psychiatry. Those who nurse the mentally subnormal should likewise have some general training as nurses, although they may not require the full training demanded of the nurse in a general hospital; and those who teach these children should have the appropriate teacher training and experience, whether of nursery schoolchildren or of older children. So too with other professional workers.

(2) The emphasis in training should be on mental subnormality as part of a more general field rather than as a subject separate from other aspects of medicine, psychology, education, employment, and social work. The worker needs to see mental subnormality as part not only of the general problem of handicapped children, but also of the whole field of preventive mental hygiene.

(3) The courses of training for personnel engaged in work with the subnormal should, wherever possible, be interprofessional. All those who will later have to work together should have a common course of training together before their advanced and specialist training, so that they may learn to see problems from many angles, and, at the same time, make the acquaintance of those who will be their future colleagues. The difficulties of arranging interprofessional courses should not be allowed to obscure their very real value.

Training can thus be considered in three stages: first, training specific to a single profession (medicine, teaching, psychology, and so on); secondly, interprofessional training; and thirdly, specialist professional training in problems of subnormality.

(4) Post-graduate courses and seminars at which doctors, teachers, public-health officials, social workers, public-health nurses, nurses, psycho-
logists, vocational guidance officers, and other workers should participate are considered to be valuable. The attention of WHO, the United Nations, and the United Nations Educational, Scientific and Cultural Organization is drawn to the desirability of arranging seminars for people engaged in work with the subnormal.

(5) The lengthening of courses of training made necessary by the growth of knowledge in this field, as in others, has made it essential that governments and professional organizations should consider very seriously the question of payment of professional and practical workers while they are undertaking specialist training or refresher courses. Some professions are better served in this respect than others, but in no country are there adequate opportunities for obtaining specialist training with pay for persons who are already qualified for general work in their profession. For doctors, resident experience in hospitals for the subnormal should be readily available, and for others of professional status comparable arrangements are badly needed. There is also a need for many more fellowships, both for nationals to study in their own countries and for interchange between different countries.

(6) Training should be both academic and practical. Practical experience in itself can be relatively unrewarding unless the student has, at the same time, the opportunity for close collaboration with an experienced teacher. The case conference is a most useful medium of teaching, for both the student and the specialist, but for it to be efficient much care has to be taken in planning it, so that workers in all the different professions concerned are brought into working contact with each other.

(7) The committee notes with regret that, for professional workers in the field of mental subnormality, there are few publications available to enable them to keep up to date in their professional work (including social and vocational aspects). At least three types of publication appear desirable: periodicals and learned journals for specialists; publications of interest to all workers in the field; and popular articles and publications to inform and educate the general public. Efforts should be made by research workers and specialists to make their findings available and intelligible to the non-specialist and to the public.

(8) The initiative of workers in the USA in forming a national association (the American Association on Mental Deficiency) is commended. The committee looks forward to the setting up of similar professional associations in other countries in which people from the various professions engaged can take part, and which the general public might be invited to join as associate members. The formation of several national associations would make possible the setting up of an international body, similar in some respects to the International Society for the Welfare of Cripples,
which could serve many very useful functions. Not the least of these would be the facilitation of interchanges among workers in different countries, and the dissemination of research findings.

(9) The importance of workers in institutions, schools, and homes for the subnormal taking on extra-mural activities is stressed. In this way their valuable experience with handicapped children can be made available to others, while they themselves can obtain the stimulation needed if their work is to be of most value.

8. Parent and Public Education

The general misconceptions regarding the nature and causes of mental subnormality, not only among the general public, but even among those whose work brings them into contact with families having a mentally subnormal child, show the amount that has still to be done to bring about an understanding attitude to those affected.

The general public still confuses mental subnormality and mental illness, and has a distorted idea of both. A further misconception, only little removed from this, is the belief that mental subnormality occurs only among the children of the sinful, depraved, or shiftless. This view is still extremely widespread.

In considering parent and public education, four groups of individuals, concerned in different ways, were distinguished:

First, the parents. When first informed that their child is mentally subnormal, parents are almost certain to be disturbed. They may be unable to accept, or to assimilate, the fact of the child's handicap. They may therefore need the therapeutic discussions mentioned earlier in the report (see page 15). It is important, too, that, when they are told of the child's condition, they should be given accurate information and should have their questions fully and frankly answered, if they are not to cling to vain hopes of miraculous cures by quacks or to build up needless resentment against others. While therefore the chances of amelioration in condition, where these exist, should be fully brought home to them, they should not be encouraged to turn a blind eye to the situation as it exists at the time.

The feeling of shame and disappointment which many parents have is in part socially determined. They can often be helped far more by association with others who also have subnormal children than by individual psychotherapy or guidance. The knowledge that they are not alone, but that their problems and difficulties are similar to those of many others like themselves, can be of great assistance to them. Parents' associations can in this way be valuable, and can enable the collective experience of a
community to be passed on to those who would otherwise have to learn everything for themselves.

The parents of a subnormal child of school age for whom some specialized form of education is recommended may need much enlightenment about the purpose of the recommendation if they are to accept it willingly. It may be difficult to convince them that their child should go to school at all, or, if he is in an ordinary class, that he would make better progress in a special class or school. It is nevertheless worth while for the case-worker to take great pains, continued perhaps over a long period, to obtain this real co-operation, so that the parents may feel that they have to some degree participated in the choice of their child's school. Many of the difficulties which children receiving special education encounter can be traced back to opposition and conflict of purposes between the home and school. The parent needs to know what is being done for his child, and why certain steps are taken in the child's own interest. Participation by the parents in the planning of school activities is a useful way of doing this.

Similar considerations apply to adolescents of school-leaving age. Vocational guidance should be carried out with parent co-operation. The attendance of the parent or parents at case conferences at all stages of the child's career is to be welcomed.

Special care has to be taken to see that the parents of a child in a residential school or hospital are kept interested in and informed about his progress. The need for continued visiting, for having the child at home during holidays where this is possible, and for sustained interest in the child should be made clear. Close liaison between social welfare services, parents, and the institution will make this possible in most cases.

A second group of interested persons are those whose work brings them in touch with many families having subnormal children. Doctors, the clergy, teachers of other children, public-health nurses, social case-workers, and juvenile-court authorities are among those who may be concerned in this way. The education of these workers should aim to establish at least three things: first, the knowledge that there are mentally subnormal persons, and experience in detecting cases in which subnormality is a factor to be considered; secondly, some idea of the ways in which the subnormal can be assisted, and of the need for this assistance; thirdly, a knowledge of where to turn for specialist advice. Some ways in which they can be given this knowledge are discussed below.

Thirdly, the general public need much more information about the mentally subnormal and how they can be integrated into the community without damage to the social structure. And finally, specialists need a broad understanding of both the difficulties which many other citizens
in the community have in understanding the problem of the mentally subnormal, and the broader community aspects.

There are many ways in which this information can be disseminated. Parents' associations have an invaluable part to play. Members of parents' associations usually join because of their concern with the problems of a particular case. Later, they frequently develop an interest in the needs of the whole class of the mentally subnormal. This interest should be fostered. They can then be encouraged to undertake much of the work which voluntary societies for other classes of handicapped children have carried out. The transition period from school to work is one field in which friendly guidance and personal contact between an interested outsider and an employer and workpeople can be of great value. There are many similar opportunities for service.

Other voluntary societies can be encouraged to take an interest. Trade unions and employers' associations are notable examples. There will very frequently be found in an employers' confederation or in a trade union branch one or more members who have a personal interest in the mentally handicapped. Such members can do a great deal to educate their colleagues. The interest of members of these bodies can be further strengthened, with great advantage to all, if they are invited to be represented on management committees of schools or institutions for the subnormal. Church organizations, too, once they are aware of the problem can sometimes help break down community prejudices. The interest and sympathetic understanding of members of youth clubs and societies, college students, and individuals who are interested in general problems of social welfare is easily secured, if attempts are made to win it. A very important part of the duties of social workers, teachers, and public-health nurses in particular, and to some extent of others concerned with the problems of mental subnormality, must be to win the attention of these organizations and individuals. This is a matter which can too easily be overlooked because it is not made the responsibility of any single individual or group; it is therefore one which needs to be constantly reviewed at the case conferences of those who work in the field.

Popular education can be given in a number of ways: through the publication of booklets giving advice both to parents and to the general public, through radio and television programmes, and film showings, and through articles in the popular press. Where parents of subnormal children themselves write articles, or speak on the radio or television telling of their own experiences and of the more general problems of others, the effect is much greater. Few things can do more to break down the mistaken stigma attached to mental subnormality than the public declaration by respected members of the community that they too have handicapped children.
It is only comparatively recently that much attention has been given to the question of public and parent education regarding the handicapped. There is little doubt that many more ways will be found in future of making the public well-informed, and it is clear that information and education which stresses the positive side, including prevention, and shows what can be done to help the mentally weak will lead both to an amelioration of their lot and to an improvement in the mental health of the community as a whole.

9. Legal Considerations

To enable the mentally subnormal to be given the care they need, legislation is necessary. The details of this legislation will differ from country to country; they are not discussed here and are matters on which legal advice should be sought. But some general principles can be stated:

(1) The main function of legislation relating to the subnormal is protective. It must protect the child and young person, the family, and the community. Children must be protected against cruelty, ill-treatment, and neglect, and must have provided for them the conditions which enable them to grow and mature and learn. Adolescents and adults must be protected against economic exploitation which may be difficult for them to withstand without help. Families must be helped to bear the additional burdens imposed by a subnormal child without unnecessary strain and expense. The community must be protected against antisocial actions carried out by those who may know no better.

(2) Over-protection should be avoided; it can be almost as harmful as lack of special protection. Unless subject to review at fairly regular intervals, protective legislation can easily become self-protective, guarding the rights of those with vested interests in one or other category of handicapped persons rather than the persons themselves. Self-protection of this sort is likely to arise where special legislation is passed to meet the needs of minority groups with little political influence.

(3) It follows that legislation covering the needs of the mentally subnormal child should as far as possible be made within the framework of more-general legislation protecting the rights and providing for the needs of all children. For example, if parents do not look after their children, legislation covering parental neglect, school attendance, and so on should suffice; it may make little difference whether the child is normal or subnormal.

(4) A necessary part of the machinery for dealing with the mentally subnormal in any comprehensive service is legislation imposing on the authorities an obligation to provide educational and welfare services for
all children. Whereas at present legal machinery is sometimes used to relieve the education or local health authorities of the responsibility of providing services for the mentally subnormal, it would often be more appropriate if the law could be invoked to ensure that the authorities carried out obligations which, as regards other children, are accepted as statutory in every developed country. As a general principle, legislation which imposes statutory duties on the authorities is likely to lead to further advances in social welfare than is legislation which imposes penalties on individuals and families for failure to carry out responsibilities.

(5) Part of the legislation for dealing with the subnormal should deal with what is called "guardianship" in some countries. In this context, a guardian is someone who has the legal responsibility for looking after a mentally subnormal child or adult and who can if necessary be paid for carrying out his duties towards his ward. Among the duties of a guardian are normally those of giving board and lodging to the person under his care, and the supervision of his leisure and his spending.

(6) Other legislation should as a matter of course ensure that adequate supervision of institutions of all kinds caring for the subnormal is available.

(7) Special legal considerations arise over the certification or commitment procedures in regard to those who are sent to institutions. In some countries there are complicated procedures requiring a judicial order before a child can even be admitted to a hospital for the subnormal. And once a child is admitted, the parents may lose all control over him. This antiquated procedure is quite unnecessary in the case of children or of those who suffer from fairly severe subnormality. It is also highly offensive to many parents. Legislation permitting voluntary or temporary admission and withdrawal from hospital is required, with safeguards added to protect a child from an unscrupulous or grossly incompetent family.

(8) A small number of mentally subnormal adolescents have to be detained in institutions for their own protection or for that of others. To protect the liberty of individual citizens, some legislation is required which makes such detention possible. Before recourse is had to this, however, the possibilities of voluntary admission or admission at the request of other members of the family or legal guardian should be fully explored. Legal compulsion should be resorted to as seldom as possible.

(9) As mentioned earlier, a distinction should be drawn between the mentally subnormal and those whose emotional development is stunted or warped, but who have normal intellectual capacities. It is not in the interests of either of these categories that they should be housed together or detained under the same statutes, and separate legislation should be drawn up to meet the problems posed by the antisocial psychopath.
10. Development of Programmes and Co-ordination of Services

Mentally subnormal children present many problems of a complicated type and different services are required to meet their needs. Throughout the report four main services have been discussed: medical, educational, vocational and employment, and social welfare. In each of these fields programmes must be developed and among them all there must be co-ordination. The problems raised are in many ways analogous to those of the physically handicapped and the report of the Joint Expert Committee on the Physically Handicapped Child \(^2\) is in a sense complementary to this report.

A general principle which has guided the committee throughout its deliberations has been that wherever possible existing services should be expanded and developed to meet the needs of the handicapped. The health programme for the mentally subnormal should form an integral part of the public-health and medical services. Its development must to a large extent stem from the existing general services including the maternal and child health, the school health, and the nursing and mental health services, and use should be made of the administrative machinery of those services.

As in the field of health, so in education. Although there will be a need for special schools to deal with the education of the subnormal, the committee was strongly of the opinion that these should form part of the general educational services. Upon the education authorities should fall the obligation to provide education for all children.

Similar considerations apply to the more general social services and to vocational training and guidance. An extensive effort has been made in certain countries to develop health and education services for the subnormal; but much less has been done for their vocational guidance and placement. The efforts at early diagnosis, care, and education may be largely wasted if no provision is made for the useful integration into society of the mentally handicapped when they reach adolescence and adulthood.

There are many reasons why these services for the subnormal should be developed within the framework of existing general services:

\(a\) The concept of normality is extended and the number of "special" services and departments is reduced. Hence, it becomes easier for parents both to accept help and to demand that adequate facilities be provided—since the obligation to provide them becomes a statutory duty imposed on the authorities as part of more general obligations which are accepted without question. In this way the needs of the subnormal are protected,

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\(^2\) *Wid Hith Org. tech., Rep. Ser. 1952, S8*
and special cuts in their services cannot be easily imposed apart from cuts affecting the health, education, and social services as a whole. Moreover, amending legislation can be passed more easily as part of new legislation affecting large numbers of ordinary children or young persons than can special legislation of a major kind which affects only a few handicapped individuals.

(b) Co-ordination at a local level is more easily secured. Children can be more easily transferred from one school or hospital to another within the same service than from a department which deals only with handicapped children to one which deals only with normal children. Specialist services are always in danger of becoming divorced from general public-health and welfare services.

(c) The conditions of service and professional competence of those who work in the field can be more easily protected. Interchange of staff becomes feasible, specialists can keep in touch with wider problems of public-health education and social and educational welfare, and it is possible to ensure that those who take up work with the subnormal have a sufficient general training before they enter the field. The community is more easily able to draw upon the specialist knowledge of the expert if his work is integrated with that of his colleagues who specialize on other problems.

(d) The integration of services for the mentally subnormal within more general services is likely to be closer, and the services themselves to be cheaper and more efficiently run.

To enable specialist services to be developed within the framework of existing services a reasonable proportion of funds should be set aside.

A second general principle is that the family rather than the subnormal child himself should be the unit considered from the public health and welfare point of view. This imposes on the various services the need to collaborate among themselves so as to avoid overlap or failure to make provision for the needs of these families.

Thirdly, as a general principle, economic and social conditions should be made such that parents will not be penalized by keeping their child at home, especially during infancy and childhood. This principle has far-reaching implications. It implies that the maternal and child health and welfare services should be competent to supervise the care of subnormal children at home before the age of compulsory schooling and to follow them through school and adolescence. They should also be able to deal with the problems of the family. It may mean that substantial family allowances should be paid to parents of subnormal children who keep their children at home; it may and should mean that domestic help, laundry facilities, and nursery schools are made available, that special transport
should be provided to and from school for those children who need it, and that home teaching arrangements are provided for children who cannot attend school.

A fourth principle is that social costs should form the basis of efficient planning. In deciding whether a child can be kept at home the adequacy of the maternal and child health and other services will be of great influence. Home care is in general cheaper and better than institution care; but its social cost may be much greater if the rest of the family is penalized because of the presence of a subnormal child in their midst.

The prevalence of mental subnormality is such that in all countries its social costs are high. These are often concealed when healthy adults are simply removed from productive and useful work and forced by circumstances to spend many years looking after a child who never develops out of dependency on its mother. The dislocation of normal family life, too, imposes social costs no less real because they are rarely assessed. There are therefore few societies which cannot afford to provide some services for their mentally subnormal, although in fact many fail to do so today.

The high social cost of mental subnormality underlines the need for much more research, as has been mentioned earlier. It also makes necessary the constant revaluation of existing services with a view to their improvement and extension. Both this committee and the Joint Expert Committee on the Physically Handicapped Child 6 have referred to the tremendous importance of the application of all known preventive methods; the assemblage of facts about the prevalence of handicapping conditions; the statistical analysis of these data; the maintenance of an active case-finding programme; the provision of easily available diagnostic, treatment, and rehabilitation facilities; and the development of methods for ensuring adequate follow-up, continuity of care, and quality of care.

To make adequate facilities available for the mentally subnormal as for the physically handicapped, the committee realizes that the following prerequisites are essential:

(1) A basic public-health programme including an established maternal and child health programme.
(2) Adequate hospital and outpatient services.
(3) Provision of nursery schools for pre-school children and compulsory education for all children of school age.
(4) A developed social case-work programme integrated with the rest of the public-health and education services.
(5) Vocational and employment programmes.

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(6) A sufficient number of trained personnel.

The various services, both general and specialized, which meet the needs of the subnormal have to be developed and co-ordinated.

Social welfare agencies can play a leading part in bringing about this co-ordination between different departments having more specialized interests. The committee calls for special attention to be paid to the need for co-ordination at a local level. At this level professional associations and workers should be closely associated with the voluntary bodies, and with parents' associations and other interested parties. The local committee for the welfare of the subnormal is one way in which this liaison can be created.

In economically less-developed countries the development of services is likely to begin in a few localities in which conditions are more advanced than those of the rest of the country. Upon these areas will rest the responsibility for developing the nucleus of a programme which can be extended and adapted to meet the needs of other parts of the country as facilities become available. University medical schools and large teaching hospitals, university schools of education, the general education and social welfare services, will have to give a lead here; and on them, as well as on the government departments concerned, will rest the responsibility for planning services for other areas.

The committee wishes to emphasize that, in order for development to proceed over a wide area, consideration should be given to the way in which this can be done with a small number of staff and with the simplest facilities, as a first step towards a more highly specialized service. The role of the public-health nurse and nursery-school teacher in giving simple advice and help to parents in communities in which there is no-one else with any knowledge of public health has been stressed. In communities with more highly developed public-health and education programmes they, in cooperation with the social worker, will continue to play an important role in acting as liaison between the family and the numerous services and facilities which they need.

The committee urges that the university medical schools and large teaching hospitals accept their responsibility for assisting in staffing and arranging diagnostic clinics in both urban and rural areas, and for bringing consultation and other assistance to smaller rural hospitals. This process can be facilitated if health departments and other agencies administering medical-care programmes develop strong personal liaison with medical schools. The joint appointment of staff members by health departments and universities is one method of achieving this.

The same considerations apply to the departments of education in universities and teachers' training colleges, which should have opportunities
of influencing the development of the special educational services in neighbouring areas. As provision is made in different countries for services for vocational guidance and training, the same possibilities should be explored.

The needs of rural communities can be met to some extent by the public-health nurse. Many of the recommendations made in the report are easier to apply in urban areas where the density of population enables more-specialized services to be set up; in rural areas there may be only one or two subnormal children in each village, and these may differ greatly in age. But with modern methods of transport field workers can serve a number of villages; and, given financial assistance, if needed, parents can travel to the nearest town, either to visit the outpatient clinic or to meet other parents and discuss problems common to them all. The very isolation of parents of subnormal children in rural areas makes the provision of field workers and opportunities for visiting urban outpatient and guidance clinics the more necessary. The need for research into the most efficient manner in which such services can be provided has been already stressed.

Co-ordination

The committee recognized that, for historical reasons, some parts of the different services (health, education, social welfare, vocational) were in some countries under the control of other departments. It would seem logical, however, in the planning of new services in countries which still have to establish these services that the authority for the various aspects (health, educational, etc.) should be within the respective departments. It was recognized, too, that the success of a programme would not be achieved unless close co-ordination was obtained not only in planning and in execution at all levels—national, regional, and local—but also in relation to the individual case.

During the different stages of development of the child the lead in bringing about co-ordination may be taken by different departments. With the young child the major part of the responsibility will fall on the public-health authorities. On them will rest the responsibility for developing an adequate case-finding programme and the collection of data, the establishment and keeping of registries, and the provision of medical and psychiatric care. The development of administrative machinery and the availability of services (maternal and child health, nursing, school health, and mental health) which serve the more general needs of the population should make this possible. It is clearly desirable that these services should be expanded to meet the problems of the subnormal rather than that a further set of administrative machinery should be established.

The committee was emphatic that where possible every effort should be made to secure early diagnosis followed by prompt remedial measures. The
most accurate and useful method of gathering the facts is that of making diagnostic and treatment services easily available in local areas. It was further of the opinion that data on the incidence of handicapping conditions are most useful if kept in local or regional registers and closely integrated with the local programme of complete services for the handicapped child. Such local data, when compiled, should be analysed at a national level, since only from a careful study of all the information on the nature and extent of the problems can a proper perspective be achieved and balanced programme emphasis be evolved. Only in areas where no services can be established is the collection of statistical data of doubtful value, producing a sense of frustration in those who might thus become acutely conscious of the problem. Where basic services exist, the collection of data will promote the establishment of specific services.

For the children of school age, the primary responsibility for all those who are educable or trainable will be that of the education authorities. Co-ordination will, however, have to be made between them and the health and social welfare authorities. At a later stage again the vocational authorities will assume important responsibilities, and the need for further co-ordination and integration of effort will again arise.

The committee acknowledged that the effort of the United Nations and its specialized agencies in planning and in integrated action gave an example of co-ordination at the international level. It urges that governments, in the development of services for handicapped children, give attention to the same need for the integration of the various services necessary to allow for full development of these children.
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<td>Alcoholism Subcommittee See under Mental Health.</td>
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<td>Bilharzia Snail Vector Identification and Classification (Equatorial and South Africa) Report of a study-group</td>
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