entities as living organisms. There is therefore no question of searching for the essential nature of the non-entities of good health and disease. The task before us is to find such criteria as will differentiate the attributes of health and disease, and such criteria are bound to be attributes of attributes, i.e., attributes of the second degree. In tackling this task I restricted myself to the physical entities that are human beings and enlisted the help of the logical theories of classes or sets. The problem then turned into the question: by which criteria can the class of human beings be divided into two mutually exclusive and complementary subclasses consisting respectively of healthy and diseased persons. Because of the unavoidable existence of borderline persons in whom the differential diagnosis of health and disease cannot be definitely decided, it is impossible to make our subclasses complementary. However, it should be possible to find criteria which will achieve mutual exclusiveness for the two subclasses of definitely healthy and definitely diseased persons. There have been a few relevant suggestions which have often given preference to attributes of the second degree which are objectively ascertainable. It seemed to me, however, that this preference has not yielded acceptable results. One has to lower one's sights and content oneself with subjective criteria. In this spirit I recommended as a solution that the criteria should consist of attributes which are abnormal by population and/or individual standards, and that they should also exhibit at least one of the following features: (a) therapeutic concern for himself experienced by a person; (b) therapeutic concern for him experienced by his social environment; and (c) medical concern for him experienced by his doctors. Whatever the shortcomings of this solution it has the advantage that it mirrors what happens in actual practice.

Mental Handicap: Observations on Current Discussion

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Current discussion on the problems of mental handicap include the frequent repetition, as if new, of material accepted as commonplace and non-controversial in the past fifty years. A summary of such material is produced and used to investigate the phenomenon.

The phenomenon

For the past several years the staff of mental handicap hospitals have been obliged to study and discuss a great quantity of advice and instruction from a variety of sources. These include documents of policy, Departmental advice and the publications of the National Development Group. Each hospital will have been visited by the Hospital Advisory Service, and in more recent years by the National Development Team. In addition, when events lead to a formal Committee of Inquiry into a particular hospital, the resulting report is studied by every other hospital, often by the request of Area or District Management requiring written conclusions and recommendations resulting from such study. The flow of 'advice' continues without there being any critical investigation of the overall character and content.

The past few years have indeed seen a number of technical advances in the field of mental handicap. Examples include the growing use of 'sign language' techniques to foster improved communication ability in the most severely handicapped, the increasing use of behaviour modification, a widening scope and effectiveness of genetic counselling, and the general availability of anticonvulsant blood level monitoring. These advances anticipate, rather than follow, any directives that come from 'on high'. There seems, then, to be a stream of progress quite separate from the stream of Good Advice. I have resisted the temptation to use inverted commas, that is 'good advice', as the advice is very rarely in any way bad, merely ineffective.

I believe certain analogies can be made that contribute some insight into the present futility of much current discussion regarding mental handicap.

Repetition

The amount of repetition is prodigious. Speaking technically, a neutral stimulus continually repeated without reinforcement induces cerebral inhibition. In this context I maintain that 'old advice', repeated frequently, cannot evoke a response other than boredom or resentment, and any gold will lie hidden in the dross.

Signal-to-noise ratio

Signal-to-noise ratio is a measurement familiar to many in its commonest context of domestic high fidelity sound equipment. The concept can be used in any communication system, and in ours anything that does not add to the quantity or clarity of a message is noise rather than signal. Our vast background of 'old hat' is noise, and where the signal-to-noise ratio is very low the message, or signal, is not heard at all.

The test

Where the signal-to-noise ratio falls below a certain level the addition of more noise will be entirely unnoticed. I tested this by ensuring that certain of my own contributions to the system were, in my terms, without meaning or value. However, I realized that, on its own, this proves nothing, and that I should have to introduce into the system a 'paper' that

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did not in any way reflect my personal views. I circulated to thirty individuals, managerial, medical and non-medical officers, a document claiming to précis all the current 'Advice' on patient care then under discussion. The document, offered as an Appendix to this article, was in fact entirely a careful paraphrase and précis from the *Manual for Mental Deficiency Nurses*, published in 1931 by Baillière Tindall & Cox for the Royal Medico-Psychological Association. It seems to fail to conform to modern fashion only in the absence of the phrase 'multi-disciplinary care'. 'Community care', on the other hand, is the title of an entire chapter (Chapter XIII) of the Manual.

Response

Four people sent notes of thanks, of whom three said they would like photocopies for certain colleagues.

The only considered reply was from a school teacher, pleased that the school seemed to be meeting the standards of care suggested, but adding: 'when comparing your notes to what actually happens [on the wards] ... I must feel a trifle unhappy ... and doubt whether such standard can be obtained in any subnormality hospital'.

Overall, then, there was little response and nobody noticed that the document was in any way unusual—and, indeed, it is not. Yet, as it contains nothing not already orthodox teaching in 1931, how can it pass as a useful contribution?

Further discussion

The document is typical in that it contains nothing new. It contributes to a set ritual and had it originated from official sources would have evoked a concerted response, probably promoting the circulation of further documents.

The useful work of our committees and working parties is randomly distributed within this background of activity I have designated as 'noise'. This noise is actively encouraged and stimulated by the highest bodies in authority, and the continued cooperation at the periphery suggests to me that it satisfies a common social need. The closest analogy is that behaviour recognized as ceremonies of ritual and magic, or even as simply 'religious'—a set pattern of belief and practice encouraged by authority with occasional episodes of special fervour when new ideas or 'revelations' became the centre of discussion and activity. Another analogy is tempting. Our Committees of Inquiry can be compared with 'inquisitions' set up to deal with congregations or 'churches' that can be identified as sinful or heretical.

In general I feel that the organisation lacks insight into the style and structure of its processes. The rituals described do not efficiently enhance or build morale and in fact contribute to alienation; they obstruct rather than further progress in our mental handicap hospitals.

Appendix: The Document

Mentally handicapped people—Future patterns of care

There are now in circulation several documents, some quite lengthy, from the various inquiries, reports, Departmental statements, etc., which require simultaneous study and action by hospital management and staff. This paper may be taken as a first attempt to précis those most important aspects that seem common to all the material so far received, that relate to hospital care.

It is essential first to have expert understanding of *normal* mental functioning and development. Apart from partial malfunction or maldevelopment all human beings follow the same general lines of development. The appreciation of inborn pathology must not distract from the fact that environment decides how far the normal, or handicapped, person attains or falls short of the potential. [*Manual, Chapter V, page 178.*]

We must provide for every child the environment that will best enable the child to develop his or her innate powers to the uttermost, so that at maturity the adult can contribute as much as possible to the community in which he or she lives. [*Chapter V, page 179.*]

A prime need is for the child to be provided with an environment rich in perceptual experience, a full and varied environment, one which encourages the development of language, sense experience, social contact, with the appropriate special training in those areas indicated by the presence of both general and particular handicap. [*Chapter V, page 180.*]

All training should be aimed towards the patient's gaining independence and confidence and over-protection is to be avoided. [*Chapter IX, page 399.*]

There are still those who question the worth of expending such effort in training the most severely handicapped. A comparison of units, equally sound in matters of housing, food, clothing and kindness, shows impressive success and high staff morale obtained as a result of ambitious therapy, as against the self-fulfilled prophecy of failure in less ambitious care. [*Chapter IX, page 400.*]

In generalizing about mental handicap we must not be misled by failing to appreciate the very wide range of mentality that is included within this term. [*Chapter IX, page 400.*]

Careful assessment makes possible the encouragement of special gifts as well as the realization of the need to treat particular disabilities. [*Chapter IX, page 405.*]

All children must have a trial at school, even if able only to derive pleasure from the simplest activities. Education should progress from primary concern with sense training, language, experience of environment, activity, concurrently encouraging full physical development, and attempting to progress to primary 'academic' education, domestic, 'workshop', athletic, recreational and social activities. [*Chapter IX, pages 406-20.*]

The school should keep full records of progress, and have available from medical sources all history and details of previous assessment procedures. The records should complete as full a picture as is possible, and be a basis for

continued re-assessment. Recording progress should be accurate and describe real activity rather than be summarized in relative, even meaningless, terms like 'fair'. [*Chapter IX, page 425.*]

At transition from school to 'adult' the future for some will reasonably be eventual placement in the community, perhaps successfully placed in either open or sheltered employment, and appropriately either with the family at home, in residential employment, or appropriate hostel care within the community, in all cases requiring continued expert support. [*Chapter IX, page 42.*]

For those adults in hospital the widest range of activity must be available, from the simplest to the most skilled. Training continues both in the work situation and through the encouragement of physical activities, and in music, dance, games, and social concourse. [*Chapter XI, pages 465-78.*]

In recent years there have been important developments variously described as 're-socialization' and 'community care' etc. Historically the attitudes towards the severely handicapped have evolved from the persecution or complete neglect of some centuries ago, first to the early attempts of training at about 1800 or so. [*Chapter XIII, page 488.*]

Later the first institutions were aimed at *cure*, but disappointment later led to an alarmist era when all social evils were deemed due to the presence of 'defectives' in the community, and the subsequent aim was to provide 'asylums', or 'colonies' for life-long care. [*Chapter XIII, page 489.*]

Eventually this aim was modified by the realization that even at their zenith of development the Institutions housed less than a third of the gravely handicapped, and but a fraction of the mildly mentally handicapped.

The realization that the vast majority of the mentally handicapped would always live within the community eventually focused scrutiny on to the need for developing community facilities. The change of social attitudes has not lessened the need for 'care' but extended our concept of what that care may be. One of the principal aims of hospital care is to fit the largest possible number of the handicapped to take their place in community life, leaving in hospital only those who cannot reasonably be cared for as well in any other way. Discharging a patient to the outside world with no reassurance of further care is inhumane. [*Chapter XIII, page 490.*]

Permanent segregation for all the mentally handicapped within institutions was never achieved, found to be impracticable, and realized to be undesirable on any account. Society now realizes its responsibility to provide, in the community, surroundings and occupations adapted to the needs of the severely mentally handicapped. [*Chapter XIII, page 491.*]

The outlook of staff in subnormality hospitals is widened, and the value of the hospital is increased by an appreciation of the development of community care. [*Chapter XIII, page 493.*]

The community, for its part, must provide the widest range of facilities, resources, and staff, so that the total pattern of care is adequate. [*Chapter XIII remainder.*]

Community Psychiatry

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My invited attendance at a College working party on community psychiatry has prompted this communication.

The working party has been examining the possibility of establishing training posts in this sub-specialty, but to date have failed to agree on a working definition of community psychiatry. The issue of whether community psychiatry should warrant a separate appointment or be seen as part of conventional consultant work also remains unresolved.

In Edinburgh, an unusual system of community psychiatry has evolved over the last eight years which, it is suggested, could offer an alternative approach to mental health care. It shows how the impetus for initiating shared community care of psychiatric disorders can come from the psychiatric services, and how working in the community can facilitate socio-medical and inter-agency approaches to psychiatric treatment.

Brown, Querido, Rutter and other researchers have convincingly shown that social and environmental factors play an important part in predisposing to, precipitating and perpetuating most psychiatric disorders, and that psychotherapy and drug treatment are insufficient to alter long-term morbidity and outcome of illness without taking these factors into consideration.

The WHO working party on 'Changing Patterns in Mental Health Care' (WHO, 1980, Euro Report 25) also observed that 'favourable results are being obtained by taking special account of the social aspects of mental illness', and concluded that 'services should be community based ... comprehensive ... with various agencies and services for each area effectively co-ordinated.'

Goldberg and Huxley, in their recent publication *Mental Illness in the Community*, show that the prevalence of psychiatric disorder in the general population is as high as 250 per 1,000, yet of these only 17 per 1,000 are referred to psychiatric out-patients and 6 per 1,000 admitted to psychiatric hospitals. In other words, the bulk of psychiatric