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## Chapter 1 : Care of the Subnormal | Aljoscha Thomschewski - racedaydvl.com

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Go to latest release Half of the employees are professionals At the end of last year, nearly half of the employees in social services were professional staff. Forty-eight per cent of the jobs were held either by social workers, child welfare officers or nurses for the Mentally Subnormal. This is an increase of positions from  Viewed as a proportion of the population, the national average rose from 1. More social workers and child welfare officers At the end of last year, there was a total increase of 92 man-labor years registered among social workers in social service compared with the year before, from man-labor years for social workers in to man-labor years for social workers this year. The percentage of employees with a degree in social work was 39 per cent in  For the first time since there is possible to notice a reduction in the number of social workers in the social services. The reduction from is 5 per cent. As a parallel with the increase of social workers in social services, the number of child welfare officers increased by 61 compared with the year before. The number of professional staff social workers, child welfare officers and nurses for the mentally subnormal was  This indicates an increase from the year before. Fewer employees with clerical training The number of employees with other college or university training decreased compared whit last year. The main reason for this decrease was that nurses for the mentally subnormal were separated as an own separate group this year. For the employees with clerical or business training one can notice a decrease from whit 77 man-labor years. Employees with other training or unskilled workers one can notice a increase by full-time equivalents compared with  The number of positions available in social services has increased in recent years. In there were positions available compared with in , and in  Big differences between counties In year , large differences still exist between counties with respect to the ratio of employees in social services. Oslo has the best coverage, with 2. Right behind we find Vest-Agder with 1.

## Chapter 2 : - NLM Catalog Result

*THE TRAINING OF LAY STAFF IN MENTAL HEALTH* By G. S. W I G LEY, M.R.C.S., L.R.C.P., D.P,H, Cotmty Medical Officer of Health Middlesex I WAST to talk first of the training of teaching staff in Junior "Training Centres with a word about Adult Training Centres and then turn to training of field staff.*

The large group of mentally subnormal have been new knowledge reducing the burden of subnormality the worst deprived of all in terms of social effort and indeed he and Sir GEORGE gave reasons why it might expenditure. He agreed, however, that country, 64, are in hospitals and 85, are under the general hospital should not separate itself from the localauthority care figures. Unwontedly straight mentally subnormal and he envisaged the new district talking on this unpopular, and therefore usually ignored, general hospitals as centres for outpatient diagnosis, theme was heard at the annual conference of the treatment, and day-care, using ordinary pxdiatricians National Association for Mental Health in London last and psediatric wards for inpatient assessment. Too many people regarded this valuable document with " suspicion mixed with planned district hospitals, each of which should include psychiatric and geriatric units. Interdependence was apathy ", ignoring it, or believing against all evidence the theme: County sistently by the other specialties than it has need of council plans for meeting the demands of community care them Lancashire had 16 hostels, planned 10 stay units or diagnostic services for the subnormal should more, and would soon have no more subnormals in hos- be placed; but Prof. Other counties had no that both should go squarely into the comprehensive hostels, no sites, and no realistic plans. They seemed to hospital of the future. He advocated a clear division of have rejected their responsibilities under the Act. Vital staff-psychologists, for by the welfare authorities. On the other hand, there were many disabled and Dr. Developments were also hindered by custodial inside, but were not-a point which applied to other attitudes of the older staff, who usually lived a closed psychiatric disorders, notably senility. The segregation social life in staff houses at peppercorn-type rent. Rigidity of mental, chronic, and acute hospitals was, Professor was also prevalent in hospital management committees, McKEOWN believed, an historical accident that must be who were mostly elderly and too often uninterested. An rectified if the standard of care was to rise " to a reason- even more sensitive and contentious area of administra-i able level " for long-stay patients. Nurses and doctors tive anachronism which Dr. The difference between and but these are not reasons for accepting an inferior stan- beds meant an increase from E to E for a. In some circumstances, a few patients i gested that 80 beds for the subnormal were needed per more or less could make big differences to salary and , population-plus the or so for psychiatric pension rights. Apart from the expense, the objection to plac- discharge of patients, the run-down of beds, and the ing these services on a common site would be the promotion of smaller units, is self-evident, and it is creation of an imbalance between psychiatry and general ironical that the harder a matron or chief male nurse services; but Professor McKEOWN saw no reason why a 1. See Lancet, , ii,  The few concessions that have been allowed for individual cases have altered the overall situation very little. Little reliance can be placed on the experience of indi- vidual clinics, because local factors may influence year by Annotations year the number of patients referred to any one centre. In women since  The pattern of 20th-century life has been who have few rather than many children the disease shifting so rapidly, however, that this decennial review is appears most often between the ages of 55 and 60; no longer sufficient to measure her changing structure but it is not uncommon in younger women. In a series of with precision. A census measures the tumour was discovered these women tend to men- struate to a later age than normal. Early diagnosis still depends detailed questions. Place of birth may be relevant to on the prompt investigation of all instances of post- diseases of later life; so, to help with future inquiries, information about birthplace is asked for in the menopausal vaginal discharge or bleeding. The answers will also help to define focuses of women some minor deviation from the usual menstrual immigrant populations. Almost half the patients had vaginal swiftness, the full analyses have taken much longer. The radium therapy after hysterectomy, but the 5-year three reports of housing from the Census were

pub- survival-rate the same as for women who underwent was lished four years later2 and the full population-migration hysterectomy alone. Here, as in other series,the tables are still " in the press ". Fortunately, such a long results suggest that preoperative or postoperative irradia- delay is not envisaged for the census: The secondary deposit Somerset House hope to complete their formidable task which appears so constantly 1 or 2 cm. Way 17 found a high The responsibility for administering the census of 1. Cwlth, , 72, In , it seems, 5. Lancet, , ii, Seattle, , 52, Some guidance on how to prepare an unbiased sample Recent Advances in Obstetrics and will be given to each resident officer. General realises that by delegating the running of the Lancet, , i,

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## Chapter 3 : Treatment for Mental Retardation: 10 Methods | Psychology

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## Chapter 4 : Mental Retardation: History of Disabilities and Social Problems

*â€": Health, Ministry of: The training of staff of training centres for the mentally subnormal. Ministry of Health Central Health Services Council, Standing Mental Health Advisory Committee.*

Treatment for Mental Retardation: This article throws light upon the top ten methods of treatment for mental retardation in humans. Trainable Mentally Retarded Children 3. Secondary and Tertiary Prevention. Mental retardation strikes the parents much harder than it does the retarded child itself. Because of the personality difficulties and problems of adjustment of the retarded child, many parents consider their life to be miserable. However, while some parents ignore the mentally retarded child, others go out of their way to help him to the extent of overprotecting him. This, on the contrary, makes one child completely unfit to learn or achieve anything. The parents therefore should be properly trained as how to handle the mentally retarded child. No doubt the mentally retarded child should be given proper love and affection. But this should not amount to something like overprotection and overindulgence. The parents must be sympathetic but at the same time they should be strong on certain points. Their child rearing practices, values and ideas should not be inconsistent and paradoxical. Their attitude towards the subnormal child should not be conflicting or rigid either. He should be given all opportunities for adequate play, open space and toys which are attractive, safe and strong. He should also be encouraged to help in the household chores so that he can develop some sort of self confidence and sense of achievement. He should be praised for his accomplishment, whatever it may be. Special education provides reasonable help to educate the mentally retarded children. For the purpose of special education, retarded people may be classified into two groups: EMR children have the I. They can go up to the 3rd to 6th grade by the time they complete school education. The aim of their education is to take care of them independently. Special small classes are conducted for EMR children where they are taught to learn social competence and occupational skills rather than academic achievement as is usually done in normal schools. Specially structured teaching materials are also prepared for the mentally retarded. Robinson and Robinson have reported special classes and programmes are conducted for people of different age groups. Students are taught vocational and domestic skills. They are taught to deal with everyday problems such as use of money, reading newspapers, application for jobs etc. Trainable Mentally Retarded Children: TMR children are much more retarded than EMR children and so their educational structure and curriculum are different. They are mainly taught to take care of themselves and to do simple occupational jobs. Regular schooling is difficult rather impossible for TMR children because of the physical problems in the severely retarded group such as seizures, lack of control over elimination etc. The basic aim of TMR education is to teach these severely retarded children how to do their daily work like washing and dressing themselves, eating properly, doing simple jobs, toilet training etc. However, it is unfortunate to state that in many cases TMR education becomes a failure in the sense, they learn nothing more than what they would have learnt at home. Kirk has further viewed that the effects on children of TMR classes are hard to assess. For the education of mentally retarders individual-centred programmes are conducted at the Institute of Defectology in Moscow, U. First the child is diagnosed as retarded by the age of 6 months. From that age till the onset of puberty individual programmes from the multi-disciplinary points of view are prepared and implemented for the child. And it is said that with the onset of puberty, the retardation is overcome. Though it is quite difficult, time-taking and costly to manage individual based programmes in developing countries like India; at-least attempts should be made on an experimental basis if not in individual units. Some psychologists and educationalists have argued normalization of education of retarded children. It refers precisely to the concept of main streaming which is of very recent origin. Particularly they hold this view for EMR children. On the other hand, they claim that special education for mildly retarded children may only develop a complex in them that they are inferior and different from others. They would feel and look more different than they are. Thus, they argue that mildly retarded children should be taught in regular classrooms instead of placing them in separate classes and

imparting special education. One of the important advocates of normalization of education of EMR children, Dunn opines the past and present practices of special education are morally and educationally wrong. Robinson and Robinson have further supported the normalization of education of mentally retarded children. On the contrary in the normalisation approach, EMR children play with their normal peers and classmates and feel that they are one among the entire group. It is also a fact that regular classes bear a greater resemblance to the real world. It is more reality-oriented. Finally, mentally handicapped children help other children to understand and accept them. Consequently the retarded child gets better scope for emotional security and adjustment. In view of its recent origin, Mesibov has reported that the data evaluating mainstreaming has been generally mixed. MacMillan, suggest that the principle of mainstreaming be separated from its implementation. Today, however, all special education has not ceased. Rather modern education for the EMR child involved a combination of special and regular classes. According to Duke and Nowicki special classes may be helpful when a child is learning to adjust to school and regular classes may be taken a few hours a day in certain subjects. Pioneers of mainstreaming view that the goal on mainstreaming is to fit the EMR child as much as practicable back to his normal peer group. Earlier it was also known as institutionalisation. It removes the retarded persons from their home environment and places them in an artificially made environment suitable for their personality development. Here they may reside either permanently for a period of time till they are cured. Usually majority of the severely and profoundly retarded persons need institutionalization. In fact, this comes to about 4 per cent of the mentally retarded people who need residential placement. More often than not the effects of residential placement has been found to be adverse particularly where custodial care is prevalent and where drugs are administered in plenty to control deviant behaviour. They live here as normally as possible learning simple vocational tasks, taking part in group therapy. The group home is much better than the large institutions and it has many of the facilities of real home for the retarded person. There are also day care centres and sheltered workshops. The day care centres train the children who are too young and too retarded to remain in institutions or to be trained in other community programmes. In sheltered workshops, vocational training is given so that the person can get a job. In India, however recently, the Dept. Some private and semiprivate institutions have started this work which is nevertheless very meagre in view of its demand. Vocational rehabilitation centres should be opened on a large scale in India to meet the demands of mentally retarded in India. Compensatory education is another type of training aid for the mentally retarders. It attempts to prevent the developmental psychological defects which interfere with educational progress. It specially helps in the prevention of cultural familial retardation by imparting structural programmes on sensory and language stimulation for the development of achievement motivation, problem solving skills and interpersonal relations. The mothers of children also receive training in understanding, caring and managing the retarded children adequately. Psychotherapy deals successfully with the emotional problems and problems of maladjustment, as well as psychological symptoms. It is a well established fact that mentally subnormal people demonstrate a number of psychological problems and complexes which can be reduced by psychotherapy alone. True, they face greater amount of stress in their day to day life in comparison to other normal people. Thus, they show symptoms of anxiety, irritation, anguish and finally aggression and violence. On other occasions, they show depression and anxiety which aggravates their already retarded mental condition. Sometimes, the psychological problems become so acute that education, special training or institutionalization has no impact upon them. Under these circumstances, psychotherapy becomes a very effective method of treatment. Usually, individual psychotherapy, group psychotherapy, behaviour modification and observational learning are included under psychotherapy. It includes one to one relationship between a trained psychiatrist in the area of mental retardation and the retarded person. Nonverbal individual therapy includes play therapy advocated by Leland and Smith , where structured and unstructured play materials are combined to match the necessity of the retarded person. While structured material is useful for mild cases, non-structured play therapy is effective for severely retarded person. Besides play therapy, occupational therapy, music therapy and art therapy may be included. Verbal psychotherapy is applicable to

those retarded persons who are capable to communicate in words with the therapists. They usually are mildly retarded adults. For the success of individual psychotherapy the rapport and the relationship between the therapist and the client is the most paramount factor. Proofs are there to show the advantages of group therapy over individual therapy. Group therapy is said to be a more economical method of treatment. Secondly, the group atmosphere is conducive to safe practice of the technique relating to peers and friends which may be ignored in individual therapy. Lastly, group therapy provides individual members with models and examples for better adjustment. It also recreates a sense of safety, we feeling and togetherness which can be of great help psychologically speaking to the retarded person who is in-secured, frightened and depressed. During the recent years behaviour modification has proved to be a very effective technique in treating the mentally retarded persons. It involves, to be more precise, the principles of reinforcement and punishment for modification of behaviour. By applying suitable reinforcements the behaviour modifier can change the behaviour of the mentally retarded person in the desirable direction.

## Chapter 5 : Social services staff (discontinued) - SSB

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## Chapter 6 : THE CARE OF MENTALLY SUBNORMAL CHILDREN - [PDF Document]

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