

SUCCESS AND FAILURE ON LEAVE

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In order to attempt to assist in assessment of the patient who is most likely to be satisfactory after leaving hospital, a comparison has been made of certain characteristics of 50 mental defectives who returned from "licence" in under two years and of 50 who remained on "licence" for at least two years. The cases were unselected, except that each of the two groups consisted of 25 males and 25 females, the latest cases obtainable being used for study. The most recent date of the beginning of "licence" was September 1950. Later, patients successfully on "licence" were usually discharged, so that adequate follow-up for two years was not feasible.

The term "licence" as used here means authorised absence from hospital for periods of three months or longer. Under the Mental Health Act, 1959, this term has been superseded by the word "leave" as used in the title of this paper for both short and long absences from hospital.

Although "licence" has become obsolete, the strains to which the patients will be put after leaving hospital will tend to be greater than those of licence, as no compulsory visiting with guidance, advice and help will be given. Consequently, as regards the future, the figures in this study are likely to give an optimistic rather than a pessimistic outlook.

DISCUSSION

The term "success" used here implies only that the patient remained on licence for at least 2 years. It means that the behaviour of the defective was sufficiently satisfactory for those with whom he or she resided to tolerate him (or her). Clearly, this "success" is relative, depending not only upon the defective, but also upon the environment, type of persons involved and the degree of tact used by those persons. In individual instances, a defective will manage successfully in one place but unsuccessfully in another. In a similar way, some persons will assist one defective to behave satisfactorily but not another. Nevertheless, in spite of these great variations, the fact remains that the stable individual with average intelligence adjusts to the persons around so that it is not impossible for him (or her) to live in the general community. One local community may be more pleasant to him than is another and he may move on to the second from the first, but he is not so greatly maladjusted that he cannot be tolerated and excluded from the community by being sent into an institution.

SOURCES OF INFORMATION

The information previous to admission has been obtained from each patient's documents. These give a reasonably accurate account of the chief traits of the patients as a whole, as they were completed by numerous medical officers, the patients coming to Hortham Hospital from several areas.

The information since admission of the patient has been taken from the patient's hospital notes. These have been written by several medical officers with, in addition, notes by the senior nursing staff.

Although many lesser prominent traits may have been omitted from the documents, those placed on the papers and used in this investigation, can be regarded

as accurate. There is no reason to think that more traits would be omitted from the documents of the cases who subsequently failed on licence than from those who subsequently succeeded. The notes were made before the result of the succeeding licence was known.

RESULTS

Conduct has been grouped in the following traits:—

- (a) Acquisitive: including theft, breaking and entering, and intent to steal.
- (b) Aggressive: including aggressiveness, arson, hot temper, bullying, violence, loss of control, trespassing, spitefulness, troublesomeness, quarrelsomeness, excitability and unmanageableness.
- (c) Unreliable: including irritability, irregularity at work, absence from school or work, absconding from hostel, untruthfulness, naughtiness, hostility to parents and dishonesty.
- (d) Sexual: including indecent assaults on males or females, prostitution, pregnancy and homosexuality.

Those who had attended Special Schools were also studied. Those classified in this report under "simpleness" and "dullness" had not necessarily attended Special School.

Conduct before admission

Of 68 traits listed amongst those who failed on licence, aggressiveness occurred in 32.4 per cent, unreliability in 29.4 per cent, acquisitiveness in 16.1 per cent, and simpleness and dullness in 13.2 per cent. Of 60 traits amongst the successes, acquisitiveness occurred in 35 per cent, aggressiveness in 30 per cent, unreliability in 13.3 per cent, and simpleness and dullness in 6.7 per cent. Sexual traits occurred in 8.8 per cent of traits reported amongst the failures and in 15 per cent amongst the successes.

Conduct in Hospital

The diagnosis made before admission to hospital is frequently altered after admission when the opportunity has occurred for more intensive study of the patient. This change is particularly noticed in the group of simpleness and dullness.

Of 168 traits recorded amongst the failures, that of unreliability was noted in 36.3 per cent, aggressiveness in 28.6 per cent, and simpleness and dullness in 27.4 per cent. Of 106 traits recorded in the successes, these three traits occurred in 34.9 per cent, 22.7 per cent and 35.8 per cent, respectively. Sexual troubles were reported in 4.8 per cent of the traits in the failures and 4.7 per cent of those in the successes. Of both the failures and the successes, 88 per cent were graded as feeble-minded.

Age on admission to the Hospital

Little difference is found between the failures and the successes, except that amongst the successes a slightly greater number were admitted when above the age of 30 years.

Age on going on licence

No special age is the most likely to give a successful licence.

Duration of time in Hospital

A comparison of the percentage of duration of time spent in the Hospital before the beginning of licence in 106 instances of failure and 50 of success shows no

advantage in a longer stay, the proportion of successes and failures being approximately similar for each period.

Doll's Social Age

Doll's Vineland Maturity Scale records behaviour with the ability to perform actions. It is graded from under one year of chronological age to above 25 years of age. It does not include certain aspects of behaviour, such as honesty or sexual, but is factual with regard to other activities. The Social Age found by this scale is the behavioural-age related to the average United States individual, and the Social Quotient is the Social Age x 100 divided by the chronological age.

This scale gives no indication that a higher or lower age accompanies success or failure.

Intelligence (Table)

The intelligence quotient, as given by the Terman Revision, the Merrill-Palmer or the Wechsler (Verbal) test, suggests that an I.Q. from 40-79 may be advantageous for success, although the higher range may not be so, as 72% of the failures gave I.Q.s from 60-79.

**Table of Intelligence Quotients in Hospital
(Figures in parenthesis show percentages)**

I.Q.	Failures:				Successes:		
	Male	Female	Total		Male	Female	Total
0 — 19	0	1	1 (2.0)	0	0	0 (0.0)	
20 — 39	1	0	1 (2.0)	0	0	0 (0.0)	
40 — 59	5	2	7 (14.0)	15	7	22 (47.8)	
60 — 79	18	18	36 (72.0)	9	13	22 (47.8)	
80 — 99	1	4	5 (10.0)	1	1	2 (4.3)	
	—	—	—	—	—	—	
	25	25	50	25	21	46	
	—	—	—	—	—	—	

Conclusions and Summary

Marked differences between the failures and successes occurred in "Conduct before Admission" and in "Conduct in the Hospital." In the first, unreliability occurred in 29.4 per cent of traits amongst the failures, but in only 13.3 per cent amongst the successes. Acquisitiveness showed the reverse tendency, occurring in 16.1 per cent amongst the failures and in 35 per cent amongst the successes. Sexual traits also showed differences, occurring only in 8.8 per cent of the failures but in 15 per cent of the successes.

In "Conduct in the Hospital," the differences were less marked. Aggressiveness occurred in 28.6 per cent of failures and in 22.6 per cent of the successes. Simplicity and dullness occurred in 27.4 per cent of the failures but in 35.8 per cent of the successes.

Slight suggestions exist of a tendency for those with I.Qs. from 40-59, and for those admitted above 30 years of age, to be successful on licence. No differences between failures and successes were found as regards previous attendance at a Special School, mental classification in Hospital, Doll's Social Age, age on going on licence, or duration of time in Hospital before licence.

These results suggest that those who are more likely to do well on licence are those who are primarily acquisitive and aggressive before admission to Hospital. Persons with these traits are those who are ego-centric and consider themselves rather than others. Consequently, when in Hospital, they will so far as possible behave well for their own sakes in order to leave Hospital as soon as possible. These

persons attempt to fend for themselves in the normal world, although they do not do so sufficiently successfully to avoid institutional life.

A previous investigation on 100 males returning from "licence" and 87 males deteriorating whilst in Hospital (Rudolf, 1950) showed that failure on "licence" is often (43.2 per cent) in the sphere of general behaviour, such as in irritability, aggressiveness, rudeness, etc., and during recreation (34.1 per cent). Amongst those who deteriorated in Hospital, the failure rate in general behaviour was similar (41.4 per cent), but during recreation it was only 6.9 per cent. These results support the idea that it was the ego-centric individual who is sent out on "licence," but that once out, his ego-centricity comes to the fore and so he is again liable to give trouble to others. A study of the criminal behaviour of the mentally subnormal when unsupervised is in the press, Middleton's (1960) study of those discharged being included.

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References

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