

CHAIRMAN'S ADDRESS

SUBNORMALITY IN THE 'SIXTIES

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It was said at this week's N.A.M.H. Conference, the ideas which are now being expressed in the sphere of mental health, are no mere drift. They have been emerging steadily, especially since the passing in 1948 of the National Health Service Act.

Let us consider the new Mental Health Act, 1959. This has changed so many time-honoured procedures that though most of its sections represent a great improvement on past law, some are bound to be disturbing. New discoveries and observations are making their mark, and the 1960's are therefore likely to become an interesting decade in the annals of subnormality history.

In the Act itself we find definitions for subnormality and severe subnormality. The "severely subnormal" are unable to live an independent life, or cannot guard against exploitation, whereas the "subnormal" are susceptible to treatment, care or training. The distinction is not to be made upon varying levels of intelligence therefore. In the case of institutional feeble-minded persons, the very need to look after them there for lengthy periods, is in itself a sign that they are incapable of living an independent life and so they should be graded as "severely subnormal." The level of I.Q., so long as it is subnormal, can be disregarded and the level demarcating subnormality from normality must be high enough to de-limit the majority of problematic dullards from the psychopathic group. I use the level of I.Q. 85. A small number of younger dullards may be judged to be able to live independently, but will very likely be better able to do so after treatment, care or training given them prior to being 21. These are the subnormal and the restrictions on age for admission and discharge are then reasonable if viewed from the above-mentioned standpoint.

The number of "subnormals" in a hospital therefore is likely to be small; the majority being "severely subnormal." Quite apart from overcoming the problem of compulsorily detaining the feeble-minded over 21 years of age, without awaiting a Hospital Order following the committing of a crime, the viewpoint I have outlined makes it possible to consider a person to fall into one grading at one time, and into the other at a later date. For example: a patient described as "subnormal" and paddling along well enough for a time, may fall into bad company and need institutional care against his will. The deterioration in his social adaptation may make it possible to certify that he is now no longer able to live an independent life and that he therefore becomes "severely subnormal" and may be detained, though over 21 years of age. Where such procedure is impossible, the new Act would provide detention for idiots and imbeciles who do not require it and never did, and fail to provide it except by a Court order for the ill behaved feeble-minded for whom forcible detention is so often necessary; such folly was never intended. The unintended pit-fall has been in the term "severely subnormal" which has unconsciously suggested to many intelligence of very low level, certainly lower than that of the subnormal. Subnormality as a term is likely to lead to much confusion because it

could be the state of mental defect in general or be limited to the better grade of patient.

The term "Intellectual Insufficiency" might meet the need for a general term which includes the two groups of people in the Act who have to suffer from intellectual subnormality. The short term "the insufficient" might then be found useful.

The enforced admission of all feeble-minded over 21 via Hospital Orders, would destroy what is so fundamental in the new Act, namely that the nearest relative has responsibility for all mentally disordered patients, including the subnormal, and including the power of discharge. The restriction of these powers in Hospital Order cases, is based on the conception that in these cases the parent has failed in his ability to manage his child, and so should properly have his responsibility curtailed and controlled. Hospital Order admission should therefore be kept down to as low a level as is possible, and compulsory detention be affected by recommendation.

The nearest relative may order the discharge of the patient, unless the responsible medical officer issues a barring certificate that the patient is likely to act in a manner dangerous to himself and to others. One may well ask what sort of danger is meant; must it be physical, such as traffic danger, or homicide or can it be moral such as homosexuality, pregnancy or crime. Should a girl be allowed to go to the care of a widowed and incestuous father, or to a prostitute mother, or a simple lad return to parents who are thieves and drunkards? It should not be forgotten that in the latter days of the Mental Deficiency Acts, neglect was defined by Courts as physical neglect.

Under the 1959 Act, the patient is discharged after six months trial, on leave of absence. Most people of experience felt disturbed at the thought of discharge after 12 or 18 months licence, when this was advocated a few years ago, for the majority of patients do not really adjust themselves in this period (1). The new Act seems to have foreseen this problem by making it possible to transfer the hospital detention to guardianship and vice-versa if it seems necessary. There is at present, inadequate experience of the use of this method of controlling doubtful types of patient, but it seems to have a good deal of merit and should be tried widely, at any rate in the present early days of the Act. The next few years will test its value.

Among other problems is that of the admission of patients. Under the new Act admission to hospital should be for a definite purpose; for investigation or observation, for treatment or training, or for nursing care which cannot be provided in the home. There are, therefore, a number of cases such as well behaved mongols or spastics, who do not require hospital admission as defined above, and it is the Local Authorities' duty to make provision for them, should a social emergency arise and they cannot continue to live at home. This care can be given in special Hostels, or in Part III accommodation under the Social Welfare Department. Such provisions make it possible for small aggregations of subnormal patients to develop into small institutions outside the hospital service; in fact their development could be encouraged by authorities anxious to have "a comprehensive mental health service." They could do all that is done for patients in hospital and if tastefully appointed, hostels could be places of choice in the minds of local parents for the treatment of their subnormal children. They could provide a nearby comfortable home, free from lower grades of patients or from psychopathic high grades, in which training, recreation, tranquillisers and rest could be given. Should the hostels turn out to be ideal for the reception and treatment of trainable high grades, the hospitals could then become unpopular dumping grounds for the more unpleasant patients. On the other hand Part III patients could live under conditions

reminiscent of pre 1948 days, when defectives were lost in Public Assistance Institutions in which no special provision was made for their care and training. It should therefore be appreciated by Mental Welfare Officers that they should continue to accept social responsibility for Hostel and Part III sub-normals whose home is, as it were, provided by the public instead of by their parents or by themselves. The patient should be encouraged to attend training centres or to continue in remunerative employment if capable of it. They should also maintain outside contacts with relatives.

Guy Milman (2) wrote recently: " Our hospitals must be therapeutic communities. Social inadequacy is the most serious aspect of mental subnormality . . . the subnormal patient must be trained in the art of citizenship " and " this must be under medical management."

Agreeing with these views I could add that all experience shows that higher grade patients come to hospital with a disordered attitude to authority, with a selfish or thoughtless attitude towards the interests and needs of others, and with no appreciation of the need to manage themselves according to principles acceptable to others. Such patients do not improve by purely punitive or restrictive methods and, in the past, many have been detained for decades because of their rebellious resistance to such management. They need understanding care over several years, by persons whose discipline they learn to respect because of an increasing liking for them. This means that nursing and medical heads of subnormality hospitals must be chosen with a special care and the patients must not be banded from one Management to another for mere administrative convenience. The patient must be allowed to express both good and bad attitudes towards certain people in charge, over a considerable period, and from this a more adjusted outlook may well develop.

In my own area around Sheffield, in order to provide this need for continuity, and in order to avoid conflicts between hospital and Local Authority personnel, I have arranged for regular weekly meetings at which the representatives from Sheffield, West Riding and Rotherham, meet the Hospital side and pool the work for the following week. Points covered are: Hospital admissions and discharges, vacancies, home and occupational reports, domiciliary visits by hospital doctors, subnormality gossip, news or developments and so on. They work as an integrated team and personnel and buildings are freely available to all. I am sure the service as provided has improved immeasurably by our regular contacts and the danger of friction has disappeared. Rotherham and Sheffield freely offer occupational centre places to patients who cannot be given suitable work in hospitals, or allow them to go to ESN Schools. Hospitals are also prepared to allow locally resident patients to attend for occupations, returning home at night.

Other areas have integrated their services in a similar way, though details may vary considerably; in fact the achievements of British psychiatry in developing principles of this type are quite impressive in comparison with those of other countries.

A summary of the sort of measures developed are described by Freeman (3).

It may be noted that only about a third of all Local Authorities have any fixed arrangement for a consultative service with hospital services, and this is to be deplored. In one or two cases the services of social workers provided by the local authority, or even the hospital authority, and of the psychiatrist employed by the Regional Hospital Board have been pooled, but this principle has not been generally followed even though there is much to commend it.

In the field of employment, little use has been made of the services provided by the Ministry of Labour. According to P.E.P. (4), only one patient in eight

obtained work in this way on leaving hospital; although approximately one third of all working patients were placed on the disabled persons register, only one in six of these actually secured employment from this source, while even fewer passed through an Industrial Rehabilitation Unit. It is of interest to note that some three years ago a quarter of all the mental deficiency patients passing through I.R.U.s in Britain went through the Sheffield Unit, and their employment record at six months and 12 months follow-up seemed as good as that of all other rehabilitees. In Sheffield we have found the I.R.U. an invaluable aid to placing patients whose employability is doubtful.

The problem of married defectives has received some attention. Shaw and Wright (5) have shown that they produce 50% more children than normal parents, that the infant mortality is higher, that the husband's employment record is poor (29% not being in employment at the survey) and that their married lives are far from satisfactory. 20% had divorced or separated and those who were still living together led cat and dog lives. Regarding their children, in 150 families, 34 were known to the N.S.P.C.C., and 11 more to the Children's Department for neglect. If an attempt is to be made to reduce problem families, then more attention needs to be given to this side of our work.

In August 1957 Murray Kempton of the New York Post wrote about the trial of a gang of seven youths for the murder of another youth in High Bridge Park: "just to pay for the lawyers alone for these children cost the state 12,000 dollars, which is the annual salary of two psychiatric social workers who might have done much to save them." Six of these lads, it was noted, were from broken homes.

In view of the fact that the vast majority of juvenile defenders come from broken homes, one might well wonder if the Mental Health Departments of our Local Authorities should not remove problem children from problem families before it is too late. Children with scarlet fever were ordered by M.Os.H. to fever hospitals years and years ago for the general health and welfare of others. Why continue to manufacture psychopathic personalities when it is in our power to save quite a number by active policies based on well accepted principles?

According to P.E.P. "there seems in the M.D. field, where there is a longer tradition of community care, to be fewer self-conscious experiments in progress outside the hospital service. Most local authorities appear to believe, rightly or wrongly, that the desirable pattern of care has been fairly well worked out, and that they know at what goals they should be aiming.

So far a good deal of thought and research has been concerned with improved psycho-social assessments and methods, with psychotherapy, with metabolic processes and genetic factors, and with pre-, peri- and post-natal influences. Already a number of articles have appeared on the value of psychotherapy for ill-behaved subnormals. Thus, Graf (6) has written that "child psychiatry is family psychiatry" whether in a Child Guidance Clinic, or a subnormality hospital or clinic . . . "there are mutual tensions between child and parents . . . especially the mother, which . . . ignored may lead . . . to a complete breakdown in the marriage bond." The rejected subnormal child in such a home is full of resentful feelings which it expresses on the world around by lack of co-operation, delinquency, immorality and so on. Milner (7) stressed the importance of sex guilt in childhood as a causative factor in delinquency in both normal and subnormal persons, and the fact that the subnormal delinquent could be successfully treated by psychotherapy.

Craft (8) has written of his experience with a new approach to the problem of self discipline among psychopathic subnormals with a delinquent background. It

does not matter a great deal whether the experiment is successful or not; what is of importance, is that the old ideas of quiet and kind, or of stern disciplinary care are being questioned and examined with scientific acumen. Moreover, there is good reason to feel that all patients deteriorate with prolonged solicitous care, and that the opportunity to manage themselves and others under a reasonable guidance brings out the best in most. We must guard ourselves against an over-motherly approach towards our patients if we are to have their interests deeply at heart.

Clarke, Tizzard and O'Connor (9) have shown the value of enlightened work training programmes and of a realistic approach to the concept of intelligence in relation to work potentials, both in and out of Institutions. I am sure that during the decade we shall see more sheltered work-shops with a distinctly industrial rather than arty-crafty purpose, both in and out of hospitals. Some of these workshops could well be shared by both Hospital and Local Authority, especially in the less densely populated areas. One of my own Institutions, Hollow Meadows, though of very mixed mental grades, manages to send to outside industrial employment, no less than 20% of its patients and has done so for years. The entertainments are the local cinema and football clubs rather than what could be provided within the Institution, and many attend local youth clubs.

A useful appointment to make, in order to develop realistic employment for patients, would be that of an "Industrial Officer," whose salary might be paid by both the Hospital Management Committee and the Local Health Authorities associated with the Psychiatric Hospitals of the area. Such a man could be an ex-D.R.O. of the Ministry of Labour, or an assistant manager from Industry with an interest in people or in social problems. He could estimate the number of unemployed but employable patients in the area (both in and out of hospital) and the facilities available in hospitals, training centres and local industries. He could then organise the employable patients to do what work is available in such premises as exist and so on. Medical, nursing and social staff under present conditions are too busy and too inexperienced to carry out such duties.

Another new approach to the psychopathic problem is that developed by Tong (10) whose experiments have shown that there is a close relationship between certain autonomic responses such as variations in the electrical conductivity of the skin, as skin temperature rise or the dilation of blood vessels in the skin, and emotional disturbances. There is reason to think that further developments of the Tong technique will enable the psychiatrists of the near future to forecast fairly accurately the stability of any patient about to be discharged from hospital.

An increasing interest in the psychopathic problem may give the psychiatrist of the near future more definite views on the problem of the disposal of cases coming before Courts and elsewhere. At present one might as well spin a coin to decide whether the psychopath should be sent to a Mental Hospital, to a subnormality hospital, a prison, a special hospital or perhaps be recommended for care under a Probation Officer. Some system might need to be evolved such as placing first under Probation, then perhaps repeating this at a subsequent offence on the recommendation of the Probation Officer and repeating this perhaps once again. It should be remembered that Probation is a service in which successful results are more frequent than failures. Should the delinquent commit a further offence, then a short term care in hospital for a period of not less than six, or not more than 12 months, with a definite discharge date, might be tried, especially if the offender has a history of long term ill adjustment. Patients under such conditions might be expected to participate in a good deal of self management according to the methods used by Craft at Balderton Hospital (8). After this, further failure would tend

to suggest deeper seated ill adjustment in the personality; the delinquent could then be sent to another hospital for an indeterminate period of time under stricter and more disciplinary conditions together with any physical or psychological methods of treatment considered appropriate. His release would be on licence and for sound conduct only. Should such further treatment fail again, then the deeply ingrained abnormality of mind might be considered not to be susceptible to treatment and the delinquent could then be sent to prison merely for long-term detention until such a time as his attitude might show signs of spontaneous amelioration.

Whatever faults such a system might be found to have, it would make much more sense than the present haphazard methods. Haphazard methods at present seem to work well with a number of offenders but generally fail with those that have a long history of ill adjustment at home and school. Responsible teachers and police officers have said on the T.V. that they could pick out potential criminals at the tender ages of five to eight years of age, by their self-centred trouble making, and their crafty underhand and similar attitudes. Why not treat them at this early age? Should not the Local Authorities Mental Health Departments look into the matter as a preventative measure concerned with their own work?

The examination of metabolic disorders, often of genetic origin, actively pursued in this country by Penrose and his co-workers at the Galton Laboratory, and to a lesser extent by Illingworth in Sheffield, are almost certain to open up new fields for research in our hospitals leading to hopes for prevention or even treatment of some subnormality conditions. For example, the spectacular results in phenylketonuria in the very few cases which have been treated almost from birth, before serious brain damage occurs, suggest that when more is known of these disorders we may be able to treat cases thought at present to be hopeless.

The presence of an extra chromosome and of a typical palm and sole prints in mongols suggest that an examination for these features and of consanguinity in their parents and especially grand-parents, should be carried out. Should genetic abnormalities be found with some reliability in the parents, it might then be possible to advise married couples showing such features, that to have children after the age of 25 would be most unwise owing to the risk of the birth of mongol children. *This example is of course in the realm of pure speculation at the moment, but its principle is worth keeping in mind.*

In the sphere of prevention, our attention must turn to pre- and peri-natal influences, for so much is already known about these conditions, that every step should be taken to prevent the birth of severely subnormal babies. The replacement transfusion treatment of " rhesus babies " is now so well known as to require no elaboration, and it is to be hoped that we shall see no more rhesus imbeciles in future. One might well ask whether the pregnant woman who contracts rubella in the first three or four months of pregnancy should have to go on with her pregnancy when the risk of her giving birth to an epileptic, deaf, blind or defective child is very high. Is there any practical reason apart from the religious or the sentimental why a therapeutic abortion should not at least be allowed to those who would wish to have one on medical advice? Though this practice does take place, it is by no means universal, some doctors fearing legal repercussions. In the same vein one might also ask whether heroic efforts should be made to save the life of a severely brain injured child immediately after its birth, when so many must be doomed to become paralysed and epileptic idiots, a terrible burden on the family and the community.

Turning to post-natal causes, we should not forget some two or three per cent of all our subnormal children owe their disabled mental state to an infection of the

brain substance, or its coverings, often as a complication of simple childhood fevers, such as chicken pox, measles and so on in the first two years of life. Prevention will therefore fall more in the field of the obstetrician and the paediatrician, than of the psychiatrist who will only have to deal with the damage as an end result. Even so, I hope that this decade will see a better liaison between subnormality psychiatrists and paediatricians, and so link the work of our own children's sections with that of local childrens' hospitals. These two branches of medicine will doubtless find that chromosome analysis will become a more important need and that genetic counselling will not only develop as a logical process, but will become more and more an important function in the prevention of mental subnormality and other genetically caused abnormalities.

And finally from people to buildings, without which we cannot work.

This week the Minister of Health has announced that the older type of Mental Hospital building is likely to be razed to the ground as of no further use to the public. Thus we must decide whether psychopaths are to be accommodated in subnormality hospitals; there are distinct administrative advantages in doing so but it would appear to me, better to have psychopaths treated by subnormality psychiatrists in buildings some little distance away from the subnormality hospital. Some interchange of patients between the two seems desirable, and so the two places should be under the same medical management. The buildings housing the psychopaths should be capable of forming small therapeutic groups of patients, not more than 20 in number, under the charge of two or three nurses and with facilities for several of these groups to meet together for recreation, employment and so on. This to my mind rules out using most large old houses which do not lend themselves to this principle. Coming back to subnormality developments, it seems to me that there is still very little discussion among psychiatrists as to the best layout for new buildings. A very good structure where area is of no great concern is a type of cruciform ward for low grade patients. Its aim is to provide two axes; one by day and the other by night, with central offices and toilets serving for both periods equally well. In my view there is no doubt that "one level care" for our patients many of whom are unsteady for many reasons, is preferable to "two floor care," but psychiatrists and nurses should get together and discuss these ideas and so have definite views on the matter. On single floor plans area discrepancies between day and night space, or patient/staff proportions, are immaterial, and toilets serve equally well by day or night.

On the continent such "flat wards" are stacked floor over floor for many storeys, each one being the same as the rest. General transport is by lift and gravity shutles are almost universal. "Up-patient-flow-systems" are easy in such buildings. One may imagine the patient getting up in his pyjamas from his bed, in a room which is not highly heated; then going towards the toilets and on to a really warm wash room, his jacket being hung on a peg; he washes in comfort, and then goes across to a dressing room where he has a locker capable of holding all his clothes; he dresses and moves on to the dining section for breakfast, and then on to the day room later. Toilets and nurses' rooms being central serve for both day and night. The patients in a U.P.F. system move constantly forward and so do not hamper other patients following on behind, the patients can be got up in three or four relays at a few minutes intervals and the whole system can be made to flow without hindrance.

Let us consider another idea; the aim of the moment is towards community care and many have spoken of the evils of "institutionalisation." This state is something which many of our buildings foster by their very design. Could not some of us persuade a hospital architect to plan a colony around a hospital village

theme? This could be planned round a village square, perhaps with a fountain and used for car parking, surrounded by such buildings as hospital office, church, library, shop, visiting room, recreation hall, workshops for patients, workshops for artisans and so on. One may imagine a street with villas in it, entitled "Gentlemen's Row" leading one way, with perhaps "Ladies Lane" in another direction! A park with facilities completes the picture. The houses should be small in number and built in a homely style, a gate to the front garden, maintained by the residents. Is it too much to ask that we get away from the uninspired aeroplane wing housing estate design we see all over the country, and which are, to me, such an abomination.

There is a need for clear ideas on what is wanted and some of our members should be prepared to consider hospital planning as a part of their professional knowledge.

And so to conclude :

We have a wonderfully interesting decade ahead of us, and I hope I have indicated some ideas which may be worthy of thought in the near future. Never before have we had so great an opportunity to make our own branch of psychiatry the most interesting of all. We must not forget however that in subnormality especially (or should I say "Insufficiency"!) our patients improve most and best by the personal approach we have to them, and that mere organisation or material provisions are *not enough in themselves*.

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