MENTAL SUBNORMALITY IN GREAT BRITAIN*

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A) Criteria by which Mental Deficiency is defined in Great Britain

All mental disorder is divided into Mental Illness and Mental Subnormality. For practical purposes, mental subnormality may be taken to mean mental deficiency or mental retardation. Mental subnormality is divided into severe subnormality and subnormality.

SEVERE SUBNORMALITY is defined as arrested or incomplete development of mind, which includes subnormality of intelligence, and which is of such a nature or degree that the patient is incapable of leading an independent life, or of guarding himself against serious exploitation, or will be so incapable when of an age to do so.

SUBNORMALITY is an arrested or incomplete development of mind, including subnormality of intelligence, which, whilst not amounting to severe subnormality, is of such a nature or degree that it requires or is susceptible to medical treatment or other special care or training of the patient.

In general, severe subnormality is usually due to pathological causes, whilst subnormality is often sub-cultural in origin. An intelligence quotient (Wechsler) below 70 may be taken as indicative of subnormality; below 50 as being associated with severe subnormality.

When emotional development is particularly immature, the condition is described as being a *Psychopathic Disorder*—this may or may not be associated with subnormality. It is defined as a persistent disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct, and which requires or is susceptible to medical treatment.

B) Numbers of Individuals recognised as being Mentally Defective

In considering these figures it is important to remember that, whilst the population of England and Wales was 46,669,000 in 1962, due to the increasing trend, it is estimated that in 1967 it will be 48,724,000 and in 1972, 50,521,000. This represents an increase of about 4,000,000 or approximately a 9% rise over 10 years.

From a survey made by Lewis in 1929, the following figures have been widely reported:

Urban Area A. (Metropolitan)	5.7/1000
Urban Area B. (Northern Cotton Town)	6.8/1000
Urban Area C. (Midlands)	7.6/1000
Rural Area D. (Agricultural)	9.7/1000
Rural Area E. (S.W. Including a town)	10.9/1000
Rural Area F. (Welsh)	10.7/1000

The above figures, however, included "high-grade" (Subnormal) children under 16. After the 1944 Education Act these would not now be dealt with under

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mental deficiency legislation, but be regarded as educational problems. Figures corrected by the removal of this group would give the following table:—

Urban Area A.	3.4/1000
Urban Area B.	4.3/1000
Urban Area C.	4.1/1000
Rural Area D.	5.6/1000
Rural Area E.	7.0/1000
Rural Area F.	6.8/1000

It should be noted that these still contain the "high-grade" over 16 and it is interesting to compare these figures with those published by Dr. Joyce Leeson in "Demand for Care in HOSPITALS for the Mentally Subnormal" (Manchester Regional Hospital Board) compiled from the Mental Deficiency Register from different areas in 1956.

Lancashire County	(2662)	1.6/1000	(mixed)
County Boroughs	(6389)	3.2/1000	(urban)
Cheshire County	(1770)	2.1/1000	(mixed)
Derbyshire and Westmorland	(2127)	2.7/1000	(rural)
All England and Wales	(141,707)	3.2/1000	

Recent Figures

On 31st December 1963 in the whole of England and Wales, there were the following patients under Local Authority (i.e. non-hospital) care:—

	Subnormal	Severely Subnormal
Under 16 years	4,075	16,903
Over 16 years	37,336	27,309
	41,411	44,212

TOTAL = 85,623.

(It should be noted that many of these were on the waiting list for hospital care and not necessarily having any special care or training.)

On the same date the following patients were resident in hospitals:—

Subnormal	Severely Subnormal
16,339	48,283

TOTAL = 64,622

Therefore, at that time, 85,623 + 64,622 = 150,245 mentally defective persons were either under hospital or local authority care. This represents approximately 3.3/1000 of the population.

(It should be noted that, by overcrowding, the 64,622 patients were in hospitals with only 61,471 "nominal beds." This should be allowed for in considering the planned provisions that follow.)

Planned Provisions for the Future

From "A Hospital Plan for England and Wales" (Ministry of Health, 1962) the following *hospital* provisions are proposed:—

	1960	1975
Total beds	59,840	63,620
Per 1,000 population	1.3	1.3

From the parallel plan for Local Authority provisions, the following places in Training Centres and Hostels are proposed:—

	1962	1972
Junior Training Centre. (Children up to 16 years, usually living at home.)	16,407	23,031
Adult Training Centres (over 16 years).	11,259	27,795
	27,666	50,826
Hostels for the Mentally Defective	947	9,907

Therefore the total planned provisions in England and Wales for the period 1972-75 is:—

Hospital	63,620
Local Authority Junior and Adult Centres	50,826
Local Authority Hostels	9,907
	124,353

As the population is then expected to be approximately 50,521,000 there will be continuous *organised* provision for 2.5 mentally defective persons per 1000 of the population. This should be compared with the estimated incidence of 3.3/1000, but it will be noted that the hospital provisions remain constant at 1.3/1000. This reflects the much greater role played by hospitals in the care of the disturbed subnormal and severely subnormal, these forming a more constant group than the subnormal, whose "incidence" varies with the cultural level of the country, the demands made by the community, degrees of affluence and social awareness etc. Further, it is assumed that there would be an appreciably increased rate of turnover in both hospital beds and local authority places, as more active means of treatment and training are applied. Thus, in effect, some beds and places could care for and treat several patients during an average patient's lifetime.

C) Action Taken on the Problems of the Individual Mental Defective

1. Occupation

Recent work by Clarke and Clarke (Manor Hospital, Epsom) and Gunzburg (Monyhull Hospital, Birmingham) has considerably revised ideas on the potential of the defective, even of relatively low grade, towards performing industrial tasks. Assembly and repetitive work on a sub-contract basis for industry is now performed on a wide scale by subnormals, both in hospitals and in training centres. This usefully employs even the relatively low-grade, and is a fair reflection of the opportunities offered in an industrialised society. In the case of the high-grades, this training for industry is gradually replacing their traditional occupation on farms, doing domestic work in private homes and hotels, and internally occupied on the routine work of hospitals and hostels.

2. Place of Residence

The idea of the hospital as a large comprehensive protective colony is now regarded as out-moded. The role of the subnormality hospital, which is staffed by medically-qualified psychiatrists, is being developed towards detailed nursing care (e.g. of the physically handicapped severely subnormal) and special investigation and treatment facilities for e.g. the autistic and deaf child, the psychotic adult, the psychopath sent through the courts etc. There are regional variations in this country, with a strong trend in some areas towards a close integration with general hospitals, as with general psychiatry. The majority of uncomplicated subnormals and some of the severely subnormals are regarded primarily as social problems for which provisions are being increasingly provided by the Local Authorities, whose mental welfare services are administered by the local Medical Officer of Health. Although this is quite independent of the hospital services, in many areas close integration is achieved. Thus local authorities provide hostels, and daily training for defectives who sleep in their own homes. They also arrange boarding out with foster parents, and, through their (separate) Education Department, provide special schools for subnormal (" high-grade ") children, residential and non-residential.

Recent ideas on the care of even severely subnormal children have been influenced by " The Brooklands Experiment " which demonstrated the social development of such children in a home, as opposed to a large institutional atmosphere. The large (1,000—2,000 beds) institution is now regarded as obsolete, and 400 beds is currently being recommended as a maximum size by Ministry authorities.

3. Problems of Group Living

The rapid development of community care, with support of the defective in his own home, has precipitated a consideration of the problem of the individual separated from his fellow-defectives. His work and leisure can be partially met by occupational centres, but he is still left, to some degree, on his family's devices. Recent work, yet unpublished, is considering the stress in a family in caring for a mentally disordered member. There is no indication to return to the anonymity of the large defective community, however.

4. Protective Measures

The process of " certification," whereby the person can be forcibly committed to care (usually hospital) has been drastically revised. It is no longer possible to " certify " a subnormal person over the age of 21, or detain him after the age of 25, unless there are special reasons for doing so. Patients who come into conflict with the law, however, can be sent formally to hospital by the courts at any age, the length of their detention being determined by the " Responsible Medical Officer " of the hospital. Similarly, severely subnormal patients can be " certified " at any age, without time limit.

In practice, very few hospital patients are now formally detained, an average perhaps being 4-5%. This means that the vast majority are free to leave at any time, but, with more careful clinical assessments, this creates very little problem. All " formal " patients, and their relatives, have right of appeal to Mental Health Tribunals.

5. Clinical and Social Measures

The whole of the country is covered by a system of Mental Welfare Officers, employed by the Local Authorities and trained in a degree of social work. They

are the usual personnel making contact with the patients (both mentally ill and mentally subnormal) in the community. They may be involved through a variety of agents—general practitioners, police etc. Both they, and the general practitioner direct, make increasing use of the rapidly expanding system of out-patient clinics for the subnormal run by consultants from subnormality hospitals. These clinics act both diagnostically and therapeutically, and enable many patients to be maintained in the community who would otherwise require hospitalisation. The hospitals also provide a domiciliary consultants service, at the request of general practitioners. All these services are free under the National Health Service.

There is considerably greater liaison developing between hospital and local authority services. Also the educational services, the courts and probation officers are coming more into the picture. In many areas the hospital service itself offers the combined and integrated resources of paediatricians, child psychiatrists, general psychiatrists, biochemical and other laboratory services, in with those of the subnormality specialists. Voluntary agencies such as the National Society for Mentally Handicapped Children, National Spastics Society, British Epilepsy Association, National Association for Mental Health, Society for Autistic Children, are increasingly being involved at a semi-professional level.

Summary

In general, two main points are to be noted in the care and treatment of mental defectives in Great Britain.

The *multi disciplinary approach* has reached acceptance at nearly all levels, so that educators, social workers, administrators, paediatricians, biochemists and geneticists, psychologists and psychiatrists are all involved in the problems, each according to the value and appropriate nature of his contribution.

Care, treatment, investigation and treatment *within the community* wherever possible, is now being widely practised, so that the chances of being "put away," the development of institutional neurosis, the production of the therapeutically sterile atmosphere of the large closed community, are being effectively diminished.

Overall, the picture is one of considerable development and alteration in a changing world. Affluence, industrialisation and the social need to "live together" are being absorbed into a new pattern directed towards maximum development of the defective's potential on the one hand, and prevention through research on the other. As with all radical changes, some turmoil is yet apparent, but both the community-care organisations and the hospital services are finding new roles for themselves in the painful, but worth-while process.

NOTE: The term 'mental deficiency' rather than the more appropriate designation 'mental subnormality' was used in this article because it is as yet more widely understood in Europe.