THE AIMS AND OBJECTS OF A MENTAL DEFICIENCY INSTITUTION.*

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The aims and objects of mental deficiency institutions in England have altered fundamentally more than once since they were first started. These alterations have, in many respects, been quite as substantial as the changes in outlook of the mental hospitals.

The first institution to be founded for defectives in England was the Royal Earlswood Institution, in 1846, and the institution of which I am Superintendent, the Royal Eastern Counties Institution, came next. Three others came shortly afterwards, and for many years this was all the provision that was made. All these five began as charitable institutions.

We still are charitable foundations to about the same extent as we always have been. For instance, my own institution still receives from £9,000 to £10,000 a year charitably, and supports about 200 patients elected by the subscribers.

In the early days we were under the Lunacy Acts, but in 1886 we came under the Idiots' Act—a special Act passed to take us out of the Lunacy Acts. The word "imbecile" for the first time then became a statutory term, to cover the high-grade cases now called "feeble-minded." It is interesting to note that we suggested the term "mentally defective" in the Bill, but Parliament was not ready for that term then, and it was replaced by the word "imbecile."

The Mental Deficiency Act of 1913 enabled Local Authorities to provide for defectives, and since that date, in addition to the charitable cases, we have taken by contract cases sent and paid for by Local Authorities. This Institution also takes defectives sent by Education Authorities under the Education Acts as a residential special school, and a few children under the Children's Act as an Industrial School. Five-sixths of our patients are now paid for in some way by local authorities under one or other of these three Acts of Parliament.

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There have been three main phases in the aim of those looking after defectives. They have been perhaps best described by Davies in *The Social Control of the Feebleminded*, and they are almost contradictory, one to another.

First: For 30 years or more we thought, like all the other pioneers in this work, that we were going to cure them.

Second: This is generally called the alarmist stage. We got into a panic, thought the whole world would soon be defective, and that in order to prevent the rapid multiplication of defectives the only thing to do was to shut every one of them up in institutions, and keep them there for life.

Third: The present phase. This is one in which we are hoping to replace the stagnant pool of an institution in which the second phase landed us by a flowing lake with a good many of the patients admitted going out again.

As regards the first stage, the curative. When our institutions were founded we all started with the same idea that inspired Seguin, namely, that if only defectives were trained in the right way they could be made self-supporting, and go out into the world again. It is the fashion to think that we dealt only with idiots in those early days, but that was not so. We took high-grade cases then just as we do now. One of the early reports of the Royal Earlswood Institution says that four of the male patients had been taught to make panelled doors, and two of the female patients had been taken on the staff as housemaids.

After years of work, however, we realized that once a defective, always a defective, and that it was not possible to put into any one of our patients the intelligence that was not there at first—that, in fact, the only thing we could do was to make the best of the intelligence that already existed.

Then, from about the year 1900 onwards there came the second phase, the stage of panic. It was realized that cure was impossible, and something else must be done. Terrible family histories were published by the dozen, describing how so many defective women in one workhouse or another had had so many illegitimate children between them. It was assumed that these illegitimate children were all defective, and I am afraid it was assumed that these women were certifiably defective.

The United States were in a far worse state of panic than England. They sent us histories of the Kallikak family, the Jukes family and so on. We were, I am afraid, obsessed with these family histories, and we thought that unless the breeding of defectives was stopped somehow or other, the whole nation would quickly become defective. No one to-day would dare to quote the Kallikak family

seriously. It would merely provoke a smile of good-humoured contempt.

But these histories did one excellent thing: they helped forward a splendid advance in the treatment of defectives, for the Mental Deficiency Act, 1913, was passed, and that puts on the Local Authorities the duty of providing the necessary institutions for the segregation and training of defectives.

That was in 1913, and then the war came and held up everything, and since then there has been a very definite reaction from the panic stage, and for several reasons.

Firstly, it began to be realized that the number of defectives in the population, if judged merely by intelligence tests, was enormous; that, as a fact, no country, however rich, not even America, could stand the financial strain of providing sufficient institutions to shut up all its defectives.

Secondly, it was realized that there had been, and still was, a good deal of ignorance about the causation of mental defect itself. It had been thought to be a disease entity, a Mendelian unitary character, and if that were so, it was reasonable to suppose that segregation would, in course of time, materially reduce the number of defectives.

But, after all, what do we mean by mental deficiency? It is merely a social convention. Can a person compete on equal terms with his normal fellows, or manage himself and his affairs with ordinary prudence? Intelligence proceeds on an inclined plane, without any steps or breaks in it, from those who have practically none, like the idiot, through the imbecile, the feebleminded, the dull and backward, the average up to the intellectual giants. Whether you call the bottom tenth of that inclined plane or the bottom twentieth or the bottom fiftieth mentally defective is merely social usage. Lest surprise be felt that I talk of as much as the bottom twentieth of a nation being called defective, let me remind you that when the United States came into the war the army was mentally tested before training began, and it was found that over 5% of the male population tested had a mental age as low as 9 years or under.

People we should call defective now were probably, a thousand years ago, considered to be highly useful members of society. Running round and hitting other people over the head with a battle-axe probably did not need much intelligence, and even nowadays a person considered defective in the more complex environment of a large city may get along quite well in the simpler life of a country village.

It was also realized that there were other causes of mental defect besides mere inheritance. How much of mental defect is due, not

to heredity at all, but to secondary causes, like disease and poisoning of the germ-plasm before conception, and to disease and injury of the child before birth, at birth, or after birth?

The more I see of mental defect, the more convinced I am of the importance of those secondary causes.

A few years ago, 10 to 15% would have been thought an unduly high figure for the proportion of mental effect due to secondary causes, but a recent number of the American *Bulletin of Mental Hygiene* says that present American opinion believes that 50% of the cases of mental deficiency are due to secondary causes. Possibly America is now swinging too much in the opposite direction, but Larsen, Denmark, is now investigating a series of cases, and he has found that amongst his lower grade children as many as 70% show evidence of some kind of brain disease as distinct from heredity, and even amongst his higher-grade children he found that 21% were due to secondary causes. We have recently tested the blood reaction of one hundred cases under 16, and we found that 25% gave a positive Wassermann reaction. This surely points in the same direction—the great importance of looking for secondary causes of mental deficiency.

Some years ago I personally investigated 318 of the cases of this Institution in reference to their family history, and in only 15 cases—that is, just under 5%—was a parent or grandparent certifiably feebleminded. That means that no amount of segregation or sterilization in previous generations would have stopped more than 5% of these 318 cases.

Personally, I think that the mistake in the past has been in relying far too much on Poor-Law figures. Naturally these give a higher incidence of defect in the parents, because the defective parent drifts to the Poor Law when he cannot support his children, and you do not get a fair sample of the population.

But even if 50% of mental defect is due to heredity, it is, so far as we know at present, a defect which, in the majority of cases, is passed on by carriers, and not by direct inheritance from parents who could themselves, by any present standard, be certified, or segregated, or sterilized. The truth of the matter is, we know very little about the inheritance of mental defect.

Then thirdly, in our problem we have realized that we have to face another factor besides intelligence, and one that matters quite as much as intelligence, and that is character, conduct, stability—that, in fact, there are good defectives and bad defectives, and the good defectives outnumber the bad by many thousands. They are getting their living in humble positions, mostly doing the dirty work, the menial jobs of the world; after all someone has to do it,

and most of us would not care to do it. You cannot shut these defectives up, and you cannot sterilize them; as the Mental Deficiency Act is drafted, they are not "subject to be dealt with" under that Act. And as a side point it was realized that defectives do not breed to anything like the extent that had been supposed. Fernald and Bernstein have both proved that amongst the mental defectives going out from their institutions who have married, or had illegitimate children, the number of children is surprisingly low.

The cumulative effect of all these points has been to again alter the outlook and the character of the mental deficiency institutions. The tendency of the alarmist stage was to force the institution to become an almost stagnant pool, with everybody satisfied to do the best they could for those defectives lucky enough to get inside its doors, satisfied that permanent care was the greatest blessing that could be given to these lucky ones, and almost entirely oblivious of the dangers, the difficulties and the sufferings of the much greater number of defectives who could not get inside because there was not room.

The only change that could or did take place in the placid calm of this very stagnant water, the ordinary mental deficiency institution, was the occasional ripple caused by a death, or less often by the discharge of one of the patients, or the rather bigger ripple made by some small building extension. These were the only possibilities of making room for any other patient, however urgent. But now we have come to believe that it is no good keeping all the jam for just a few so that their bread may be completely covered. The jam must be spread over just as many slices as it can be made to cover, even if it is a bit thin in places. No patient must be considered a permanent resident, no case should be detained if there is any reasonable chance of its making good in a simpler environment. And if we are not quite sure whether the defective will make good or not, we ought to take the risk.

To put it shortly, this means that the institution should be a flowing lake, always taking in, always sending out, but sending out only—and this is a most important point—to other smaller lakes, each of which shall be fed from it.

To you who are nearly all, I suppose, medical officers of mental hospitals, that probably seems nothing much to make a song about. The sending out of patients able to look after themselves is just what you are always aiming at, but to those of us who have been accustomed to the stagnant water, it is more or less of a revolution.

I believe that all defectives in the area served by a mental deficiency institution who need more than supervision ought to come first into the one big central institution for that area, where

they can be studied, tested, trained, stabilized and sorted out. That is the inflowing stream.

It is the greatest mistake to send cases from their own homes direct to the guardianship of foster parents, who probably know as little as the parents did, how to manage them, though owing to the great shortage of beds it is at present often the only thing that can be done.

Many of the inflowing stream will always remain in the institution—for instance, the low-grade custodial cases, the wet and dirty cases, the epileptics, the troublesome fighting cases, the high-grade unstable ones, the men guilty of sexual crimes before admission. But there should be, and there will be, a good many who, after testing and training and stabilizing, can be sorted out and put into the outward stream. For the higher grades this testing will include being allowed out in the town with two other patients, and without staff. Three together are safer than two. Two hang together and do not split on one another, whereas with three, one generally tells if anything is going wrong.

This outward stream should carry some to the hostel branches of the institution, firstly, to be tested in day service from the hostel.

In America a good many defectives live in hostels, and go out to factory work in the town. We have tried this, but it does not work very well, partly because of the unemployment in England, and the difficulty of getting regular work. Some institutions, however, successfully send some male patients out daily to work on neighbouring farms. After a period of successful day service from the hostel branch the patient is next tried at "living-in" service. In my opinion this "living in" service should be conveniently near to the hostel, so that the patient can come back to it during her time off. The chief thing a defective girl going out to service seems to feel is the deadly monotony of the ordinary small house after the constant change of life in a big institution. If the situation is near the hostel the girl can come back to the hostel for her time off, for gossip, for her Guide work and for her holidays, and the Matron supervises her money affairs, her clothes and her going out. Eventually, after years, there may come final discharge.

The outward stream should also carry some, perhaps not many, back to their own homes on licence, to work outside their homes, to work inside their homes, to be cared for at home. I say perhaps not many, because if the home has, in the first instance, failed in care or produced instability or unmanageability, the home will probably produce a return of these symptoms after a short time, in spite of the institution training.

The outward stream should carry quite a number of patients to foster-parents on licence, to work outside their new home, to work in their new home, or to be cared for in their new home.

The best type of case for foster-parents is the medium grade, well-behaved, stolid defective, who is content to sit about and do little—the imbecile. Foster-parents as a rule will not bother with low-grade wet and dirty cases, and the high-grade defectives will not be bothered with foster-parents looking after them. They feel the deadly monotony of an ordinary village home after the change, the gossip, the something always going on, that makes the life of the modern institution, and the foster-parents cannot control them.

The outward stream will lastly carry some patients to a simpler type of institution on licence. By a simpler type of institution is meant the special wards of a good workhouse, or one of the existing small homes. These also would be quiet, well-behaved, generally older defectives, mostly of a medium grade of mentality.

The essence of the scheme, however, and a necessity for its smooth working, is that all defectives who have once been admitted to the institution, whether later, at the hostel, in living-in service, with foster-parents, or in the simpler type of institution, must remain on the books and be on licence from the central parent institution. This ensures absolute and immediate fluidity of movement in all directions inwards as well as outwards, between the centre and between all other methods of treatment.

It should be just as easy to move inwards again to the central institution or to move from one to the other of any of these methods of treatment as outwards from it. This can only be secured by everyone sent out from the central institution continuing on licence, and fortunately there seems to be nothing in the Mental Deficiency Act to prevent licence for any length of time. Many of our patients have been on licence for years—one continuously since the year 1919. They are all of course under supervision, and are seen from time to time wherever they may be, but they all remain on the books of the central institution.

It is most important when you are dealing with defectives to keep them on a "bit of string"; it is the thing that ensures good behaviour more than anything else. Some 25% of the cases on licence have to come back every year for one reason or another. This does not include those coming back for holidays or for small illnesses, or because they are out of a job, but for bad behaviour, or because the foster-parents cannot manage them, or because the foster-parents are unsuitable, or there may be changes of circumstances.

The great advantage of licensing these patients who go out is,

that you can shift anyone anywhere at a minute's notice at the least hint of any danger or trouble. It is this power of instant removal that is the great safeguard. We have had several cases where if we had had to wait for a magistrate's order before taking action there would have been disaster.

The whole point about this new view of the proper function of the modern mental deficiency institution is one big central institution taking all grades and all ages to which all defectives needing more than supervision come. Connected with this central institution are, of course, all the ordinary things, upper and lower grade schools, training shops for all kinds of trades, and so on, but also connected with it are hostel branches for service outside, farm colonies, one or more simpler types of institution, and many foster-parents.

I have spent so much time on what I believe to be the great change that is taking place in our outlook that there is not room to say much about our other and older aim, the making the best educationally of the material we get.

We are under the Board of Education as a special school for defectives, and under the Home Office as an industrial school, as well as under the Board of Control, but we do not worry in the least under which Act of Parliament a case comes to us. The patient goes in the right class according to mental capacity, and nothing else is counted. It is vital to have enough separate classes to allow of grading and classification. We have over the whole institution some twenty-two classes. More than half the school teaching is manual work, but at the age of 16, and often before that age, they go to the manual training shops. We have one great advantage, and that is, that at whatever age our patients come to us they come with the idea of being trained and of working. We aim at making everything we use, all our boots, our clothing and uniform, all our furniture; in addition, we have selling shops for brushes, baskets and mats. We do not yet weave all our own materials, though we do a good deal.

The high-grade patients are the skilled workmen of the colony, the medium-grade are the labourers, and the low-grade the drones, but they have to be pretty low grade before it is not possible to find some job for them.

One of the great advantages of an all-grade institution where the high-grades do the work for the low-grades is that you reduce enormously your average weekly cost as compared with an institution taking only low-grades, where all the work has to be done by a paid staff.

We have, of course, a farm, gardens, and orchards, a seaside home,

which is a great boon for the many patients you dare not allow home for holidays—and two branches run as hostels.

In my opinion the more you have in the way of Guides, Scouts, school plays and such-like, the better for the institution and its patients. Our Annual Report generally contains photographs of different scenes out of the school plays that take place each year. The dressing-up and the acting in public are excellent training for all types of defectives. This Christmas our girls' school, for instance, gave five public performances of their play, and took about £130. This money, after paying expenses, provides the funds for the Guide summer camp.