A SURVEY OF 200 WOMEN DISCHARGED FROM A MENTAL DEFICIENCY HOSPITAL

By

M. W. G. BRANDON, B.A., Dip.Ed.
Clinical Psychologist
The Fountain Hospital, London, S.W.17

Introduction

THE purpose of this survey was to assess the abilities and present status of all the adult women classed as feebleminded who have been discharged from the Fountain Hospital. This paper is not a comprehensive assessment, but a survey of these patients' past history, together with an interim report on their rehabilitation. In the majority of cases, the present whereabouts and occupation are known by the social worker and have been re-checked over the past eighteen months in the course of normal follow-up contacts.

Previous Studies

A large number of follow-up studies of patients, certified as feebleminded or having left educationally subnormal schools, have been carried out. Tizard (1958) mentions five reviews in "Longitudinal and follow-up studies" and gives a résumé of 25 further studies in *Mental Deficiency, the Changing Outlook*, edited by Clarke and Clarke. The success rates vary from 36 per cent. in Town's 1931 study to 88 per cent. in Haskell and Strauss' 1943 study. This considerable variation is not surprising, as the groups, as well as the after-care and the criteria of success, differ widely.

O'Connor and Tizard (1956) conclude in *The Social Problem of Mental Deficiency*, after quoting Charles's 1953 paper, that his "study and the many others of its kind fully bear out the statement made earlier that it is quite false to think of feeblemindedness as something fixed and incurable. It is, rather, an administrative concept and as such is related to the conditions and facilities available in the community."

Description of the Patients

The Fountain is primarily a hospital for mentally defective children, but there are 80 beds for feebleminded and imbecile women at the South Side Home at Streatham. (This hostel is described in Hilliard, 1954.) The present survey of 200 women deals with all those adults classed as feebleminded who have been discharged from this hospiatl. All the patients had been certified under the Mental Deficiency Acts (Section 6, 8 or 9) except 23 who had been admitted as "place-of-safety" cases (Section 15) or under Circular 5/52 (Short-term Care). The dividing line between feebleminded and imbecile is, in some instances, very difficult to draw. In the present survey, the division has been made mainly on the basis of the intelligence quotient, those with an I.Q. above 50 being labelled feebleminded. The 200 discharged women form about 70 per cent. of the total number admitted with an I.Q. over 50.

Of the 200 direct discharges from this hospital, 30 were direct admissions, the remainder came from other institutions. Many of the latter group were

described as "working patients" regarded as being able to do a certain amount of simple work within the hospital, but their previous institutions did not consider them suitable for licence. The first of the 200 patients was discharged in 1922 and the last in February, 1958; only 8 were discharged before 1946 when there was a policy change and rehabilitation became one of the main aims. Some of the main data concerning these patients is given below:

	Average	Range
Age of entering a mental deficiency institution ..	22 years	2–71 years
Time spent in mental deficiency institution ..	13 years	<1–38 years
Age at discharge	35 years	17–65 years
Number of years discharged (at June, 1958) ..	5 years	<1–36 years

	Percentage
Entered a mental deficiency institution 14 years or under ..	6·5
Entered a mental deficiency institution 15–26 years of age	70
Entered a mental deficiency institution 27 years or over ..	23·5

The intelligence of the discharged group is as follows. One hundred and twenty-three of the 200 have been given a Wechsler Bellevue test, the average I.Q. is 84·1 with a range of 52–113. Twenty-two others were given the verbal scale only of the Wechsler Bellevue test. These 145 are shown in Figure 1.

TABLE I

Intelligence Test Results of Discharged Patients

Test	No. Given	Mean I.Q.	Range of I.Q.
Wechsler-Bellevue	123	84·1	52–113
Raven's Progressive Matrices	128	83·7	59–111
Terman and Merrill revision of the Stanford Binet	117	65·0	40–93

It will be seen that, of these 145 patients labelled and certified as feeble-minded, only 11 per cent. do in fact fall within this category when it is defined with respect to intelligence, i.e. an I.Q. between 50–70.

The results of the other tests are given below. Direct comparison is difficult because individuals had different combinations of tests. Omissions may have been due to the unsuitability of the test, to specific handicaps of the patient, or to lack of time on the part of the psychologist.

One hundred and seventy-six out of the 200 have a score on one or more of these tests, 78 have a score on all three. There are wide divergencies between one person's score on the three tests, as described by Mundy and Maxwell (1958), who discuss the reasons and provide a correction factor. There are also considerable differences from one time of testing to another. The majority show upward rises. The tests were administered by four psychologists, the majority by Mrs. L. Mundy, who also gave these women therapeutic and remedial help. Rises in I.Q. have been shown both after coming into an institution from a bad home background (Clarke and Clarke, 1954), and on going from the institution to a post outside (Mundy, 1957). On the other hand, preliminary comparisons between the Wechsler-Bellevue scale and the new and better standardized Wechsler Adult Intelligence Scale indicate that the former test gives higher scores in the older age ranges by allowing more for deterioration. The 123 who have scores on the whole of the Wechsler-Bellevue test have an

average verbal I.Q. of 81·5 and an average performance I.Q. 8 points higher, 89·7. It will be shown later that the majority have not had a normal upbringing or schooling. The whole problem of the use and meaning of intelligence tests with women who have had so many early adverse influences is a complicated one and has been discussed by Clarke and Clarke. As Jones (1946) wrote, "It may be useful to repeat once more the generally acknowledged fact that the validity of mental tests diminishes when we apply them to groups deviating in cultural norms from the original standardization group."

It does seem that this group are brighter on average than those found in other institutions. However, there is probably a considerable degree of overlap. O'Connor and Tizard (1954) found that the average I.Q. of a representative group of adult institutional feebleminded persons was just over 73, using the Progressive Matrices test. They also found that two-thirds of the adult institutional feebleminded had I.Q.s between 60–80.

Past History

The handicaps listed below are those which were found most frequently. It is realized that some patients might have more serious handicaps than those mentioned, and that the fact that their mother had died or deserted them when they were young would not be the same handicap for different children. An "average" case history is given in Appendix I. The handicaps can be divided into physical ones such as deafness, eye defects, epilepsy, etc., and social and emotional handicaps such as illegitimacy and death or mental illness of parents. In thirteen cases there are only a few details in the social history from which to assess the handicaps, in a further few cases specific facts were not known, so that in the tables below, the number in each group is given, together with the percentage this represents of the total group in which this fact is known*. In Table II six had both a sight, hearing or speech defect and another physical handicap.

Table II

Physical Handicaps	No.	Total	Per-centage
Sight, hearing or speech defects	51	190	27
Other physical handicaps	26	186	14
Total with a physical handicap	71	190	37

(a) *Physical Handicaps*

These handicaps are taken from the heading "physical defects" on the case papers which are completed by the Medical Officer. The "other defects" include epilepsy, endocrine disturbances and any loss of use of limbs. In some of the older cases these defects are not well documented. It will be seen that about a quarter of the group have a sight, hearing or speech defect. This would tend to be a handicap educationally. Not included in the total of 37 per cent. with a physical handicap are the large number with non-specific aches and pains.

* Data from case notes from Fountain Hospital and previous hospitals and from files of L.C.C. Mental Deficiency Departments.

TABLE III

Social and Emotional Handicaps	No.	Total	Per-centage
Illegitimate	45	187	24
Mother or father died or abandoned child before 5 years of age	63	187	34
Not brought up by own parents from 0–10	101	187	54
Brought up in an institution	72	187	39
Total with one or more of the above handicaps	114	187	61
A parent, or parent substitute, psychotic, emotionally unstable or in a mental hospital	62	187	33
A parent described as dull or defective	31	187	17
Total parents alive but with a handicap	78	187	42
Mother or father died or abandoned child between 10 and 21	37	190	19
Total with one of the above handicaps	167	191	87
Stated to be emotionally unstable on admission	150	189	79
Has been in mental hospital	19	187	10
Has sibling described as defective or mentally ill	40	186	22
Total with one of the above handicaps	192	192	100

(b) *Illegitimacy*

Forty-five (24 per cent.) of this group are illegitimate. This is a much higher figure than that for the children admitted to this mental deficiency hospital. Hilliard and Kirman (1957) write that in a series of 350 admissions to this hospital, twenty-five (or 7·1 per cent.) were illegitimate. The rate for the general population is now about 5 per cent., varying from district to district, but considerably lower than the 24 per cent. found in these discharged adult patients.

(c) *Upbringing*

In the majority of cases, the previous home life of the 200 women was disturbed. Only 13 had lived with their own two normal parents until they were 21. They appear to have had a very high proportion of defective and mentally disturbed siblings; 40 (or 22 per cent.) are mentioned in the social worker's notes. This may arise from a number of factors, and is partly due to the fact that this is a selected group. Families who already have one difficult member are more likely to ask for institutional care, and in some cases when they came from very adverse homes, the same disadvantages are acting on all the family. There are four pairs of sisters in the present 200 and they are all managing their lives in the community, so that in eight cases at least the "defective sibling" is quite capable of earning her own living.

Seventeen per cent. of the parents are mentioned as dull or defective. In some cases these statements are in old notes where immorality and poverty are sometimes used synonymously with deficiency.

Kirman, in Hilliard and Kirman (1957), writes that a child of borderline intelligence is much more likely to be classified as mentally defective if his environmental circumstances are unfavourable. This is equally true of the

adolescent to early twenties group. The term "emotional disturbance" is used widely and covers a variety of very different conditions. This is discussed later under the heading of personality.

(d) *Schooling*

The methods by which members of this group have been fitted into or excluded from the educational system differ both from one county to another as well as from one time to another. The type of schooling that these women had is given below, together with their Wechsler full scale I.Q. where this is available.

TABLE IV

School	No.	Per-centage	No. Tested	Mean I.Q.
Elementary school	58	29	39	88·4
Mixed elementary and special school	34	17	22	81·4
Elementary and not known	7	3·5	5	79·2
Private school or convent	8	4	4	86·3
Special school	39	19·5	22	83·6
Special school and not known	6	3	6	86·6
Special school and institution	4	2	3	63·3
Excluded from special school	3	1·5	2	61·5
M.D. institution only	14	7	8	83·1
No schooling or less than 1 year	2	1	0	—
Not known	25	12·5	12	85·5
Total	200			

Thus 99 or over half the known cases spent some time in an elementary school. Any changes that occurred from one type of schooling to another, where both were known, were always from Elementary (Primary) to Special School and from Special School to Institution.

(e) *Work Before Certification*

Over half of the known cases worked before they were certified. The figures are given below:

TABLE V

Occupation Before Certification

Type of Work	Number
Domestic work	52
Factory work	12
Laundry work	5
Mixed Domestic/Factory/Laundry	13
Other (shop assistant, farm worker, etc.)	13
Large number of varied posts	13
Total	108
Not worked before came to institution	67
Not known	25

(f) *In Prison or on Probation*—prior to certification

Twenty-seven, or 14 per cent. were put on probation, were remanded, or had been to prison before they were certified. The most common offence was

theft. In some cases such small items were involved that it seems likely that the incident was only one aspect of a difficult situation and was used to bring the woman before some authority.

(g) *Cause of Certification*

It is often very difficult to see why a particular girl has been dealt with under the Mental Deficiency Act rather than by such methods as probation, hostel placement, or fostering. Of these 200, 25 per cent. were certified mainly because of their having an illegitimate child, together with, in most cases, no stable home. It seems probable that it was the density of problems in this group rather than any particular single cause that led them to be certified. All the women had at least one of the handicaps listed in Tables II and III, and all but 30 had more than one. Educational backwardness certainly helped to mask their intellectual capacity, but above all there was no one in the community willing to take responsibility for them in their late teens and early twenties.

(h) *In Hospital*

As stated previously, 130 women came from other mental deficiency institutions where they had spent an average of 10·8 years. Whilst in hospital their main occupations had been domestic work, laundry work or sewing. Very little specific training for work outside the hospital or remedial teaching was attempted before their admission to this hospital. Since their admission, it has been limited, being in the main informal and dealing with such matters as personal hygiene and correction of anti-social manners.

(i) *Personality*

Aspects of personality are extremely difficult to describe in a quantitative way. Whatever the method of assessment, the general picture is consistent. The majority of this group were certified in adolescence because they had a type of personality which gave rise to difficulties and no relatives who would be responsible for them. Backwardness and deficiency were of almost secondary importance. From case notes and certificates it becomes obvious that the disturbance in personality rather than the lack of intelligence was giving rise to the most pressing problems.

Various diagnoses and descriptions are given in the notes. The most frequent comment is that the girl has a very bad temper. This is probably part of the general picture of immaturity in adolescence accompanied by emotional instability. A number of girls were noted to be dishonest, and a further group were said to have immoral tendencies. The diagnosis of depression appears to be a broad one, varying from a dull flattening of affect which might be the result of institutional upbringing, to a serious depressive illness.

The patient's personality is usually described on admission and the following table is taken from these descriptions and the reports of the social worker before admission. With such a variety of writers (doctors, social workers, ward sisters) it is extremely unlikely that there is much consistency in the terms used. The patients may have been depicted as rather less favourable than they were to secure admission, but it is interesting that, if this occurred, it was personality defects rather than lack of intelligence that were stressed. A number were described as having more than one personality defect.

TABLE VI

Description of Patients' Personality on Admission

Personality Description	Number	Percentage
Bad-tempered	45	
Emotionally unstable	43	
Depressive	31	
Moody, obstinate, sullen, slovenly, apathetic	26	
Immature	21	
Hysterical	20	
Paranoid, deluded	13	
Schizophrenic, schizoid	13	
Beyond control	8	
Inhibited, lacking in self-confidence	7	
Obsessed	4	
Aggressive	3	
Psychotic	1	
Total described as one of the above	150	75·0
Dishonest, or before the courts for stealing	20	
Immoral, or having an illegitimate child	36	
Total described only as dishonest or immoral	25	12·5
Total described as any one of the above	175	87·5
No personality defect noted, or stated as pleasant	14	7·0
Not known	11	5·5

The group of 14 where no personality defect is specifically mentioned nor were they described as immoral or dishonest have their main reason for certification given below:

Low intelligence, I.Q. below 76, and no one willing to care for patient	9
Immediate relatives very disturbed	3
Leaving special school and no home	2
	14

This means that, apart from these 14 where no personality defect is noted, most of the traced remainder of the group are described as having a defect in their personality. Some of these descriptions are true of many children and adults and would not be remarked on, if it was not for their high incidence and that in spite of looseness of definition they do appear to have some predictive value as described later.

(j) *Licence*

One hundred and fifty-three women worked on licence from the hospital before their discharge, and were on licence for an average of 2½ years. They had an average of 2·3 jobs each. Seventy-six had only one post and 32 had two; one woman had 12 and one 10. The remaining 43 had between 3 and 8 changes. The reasons why a particular girl changes her post, or is found unsuitable, are very complex. Employers of mental defectives vary considerably, so that, when a patient is returned as unsatisfactory, it is not always her fault. In the

main, however, employers are carefully selected and give the patient considerable help, sympathy and understanding. This is borne out by the fact that half of those going out on licence had no change of employment and many are still with the same employer now they are discharged. Of the remaining half who had from 1 to 11 changes, the reasons, as far as they could be ascertained, are given below with percentage figures for 193 changes of employment.

TABLE VII

Reason Given for Patient's Change of Employment on Licence

Reason Given	Number	Percentage
Unsatisfactory work or behaviour	65	33
Patient's request	25	13
Patient's health	22	11·5
Change of circumstance in employer	16	8
Absconded	10	5
Unsuitability of employer or post	9	5
Relatives moving or at relative's request	5	3
Patient unsettled at work	2	1
Suspected theft	1	0·5
Reason not recorded	38	20

The type of work done whilst on licence is given below. Several patients did more than one type of work.

TABLE VIII

Type of Occupation Whilst on Licence

Work on Licence	No. of Patients Who did this Type of Work
Hospital domestic	88
Other domestic work	90
Factory	18
Laundry	18
Other	8

Hospital domestic work was preferred for a number of reasons. The rates of pay are fixed on a National Scale and are relatively high; board and lodgings are provided and usually a uniform is worn. This means that the basic difficulties in life are dealt with. There is also companionship, which can be a major consideration for those who have spent many years in an institution. Being the only domestic worker for a family can be extremely lonely. Domestic work in a hospital is also more repetitive than it is in a private house. In a household where only one domestic help is kept, it is difficult for a deprived girl to fit into the family. However, in a number of cases this arrangement has been most successful and each case must be decided individually.

The heading "Other domestic work" includes, besides this family domestic work, routine domestic work in canteens, factories and laundries. Seventy-four per cent. of the women are doing the same kind of work (i.e. hospital domestic, other domestic, factory or laundry work) as they did on licence. The remaining 47 were either discharged without a period on licence or went, on licence, to relatives instead of to a residential job.

DISCHARGED

Only 2 of the 171 patients whose whereabouts are known have been re-certified. One of these went to another institution and has since been discharged, and the other is now working on daily licence from our new hostel for working girls. Contact has been maintained with 171 of the 200, four of these have since died, leaving 167.

The 29 cases whose addresses are not known at present will be discussed first. Twelve of those whose whereabouts are at present unknown, left before a social worker was appointed, and two more were place-of-safety cases and so not here long enough for much contact to be made. Many of the remainder have been followed up for a number of years and it would be known in most cases if they were not managing in the community. There is no fixed follow-up policy; those discharged are encouraged to keep in contact, but there is no pressure to do so. Contact is maintained mainly through a summer party, Christmas letters and by the social worker's help in getting them new accommodation and work when this is needed. Suitable accommodation is one of the main problems, as these patients lack relatives who are willing to give them a home, and lodgings are difficult to find.

None of the former patients whose present address and occupation are known, are in other mental deficiency hospitals, in prison or on probation. Since discharge, three have been "in trouble with the police" but have not been sent to prison. None have been before the courts for prostitution. It is unlikely that any of this group are earning their living in this way, although 7 have had illegitimate children since discharge.

About 20 have returned at some time to the South Side Home, usually for less than a fortnight. It is possible that some of these could be classed as temporary "failures" in that they had nowhere suitable to go, or no work; others were just coming back to the hostel for a night's lodging before going on holiday. Two are at present admitted informally; one has retained her former work and goes to it daily, and the other works in the hospital laundry.

The present living arrangements of the discharged women are given, together with the figures in each group and the number who have been tested, with their average Wechsler Full Scale I.Q. and range, where this is available (123 cases). An additional 22 Wechsler Verbal Scale I.Q.s have been added in both Tables IX and X.

TABLE IX

Present Living Arrangements

Category	Number	Number Tested	Average I.Q.	Range of I.Q.
Living independently	62	48	86	68–108
In a resident post	57	45	80	54–113
With relatives or dependent	48	39	79	52–102
Lost and dead	33	13	89	67–100

The social worker and psychologist placed each woman into one of three categories. The first category comprises those who are completely independent, that is, living in her own house or lodgings, on her own, with another woman or with her husband. The second category includes those in a more sheltered environment, such as that of a resident domestic or hospital domestic. This group are living as independent a life as many other people, but the difficult problems of board and lodging are dealt with. The third category comprises all

those who are living with parents or relatives or are dependent on them. Here in addition to board and lodging being provided, probably someone is present who feels responsible for them and who can give advice. There are some women in both the second and third categories who would be quite capable of running a home of their own and living independently. The three women (one certified and two admitted on an informal and temporary basis) who are living in hostels attached to the Fountain are included in the third category.

Present Employment

Of the 167 individuals traced and alive, 114 are working gainfully, 6 are retired, and 17 (10 per cent.) are not working. The figures in each occupation are given in Table X together with the number tested and their average I.Q. and range.

Table X

Employment, Occupation and Intelligence

Type of Work	Number	Number Tested	Average I.Q.	Range of I.Q.
Private domestic work and housewives	71	56	82	62–99
Hospital domestic	42	29	81	54–113
Factory	17	16	87	78–108
Laundry	9	9	87	59–102
Other	5	3	87	70–108
Total working	144	113	83	46–113
At home with relatives or friends ..	9	8	80	64–100
Attending occupation centres	4	4	56	52–63
Mental hospitals	3	2	67	52–81
At South Side Home	1	1	85	—
Total not employed	17	15	72	52–100
Retired	6	4	83	73–101
Not traced	29	10	92	80–100
Dead	4	3	78	67–88
Total number	200	145	82·5	52–113

The women who are not working have either an I.Q. below 64, or are very emotionally disturbed. They differ from those working in the length of time they have spent in institutions; this is either less than a year or over 25 years. It appears that this group comprises both the very "institutionalized" woman and those whose relatives merely wanted temporary relief. Those who have retired, have not been traced, or have died, are also shown in Table X. It will be seen that the women who are untraced tend to be brighter than the rest and contain no very dull members. The deaths were due in one case to a kidney disease in a young girl and the remaining three cases to illnesses associated with old age.

Marriages and Children

Forty-six out of those discharged are married, about a third go out to work as well as looking after their homes. It is hoped that the married group will be described in more detail in a later paper. Thirty-one of these married women have had children; 70 of these discharged patients have had 160

children. These include most of the children studied in an earlier survey (Brandon, 1957). Their average intelligence level was then found to be within normal limits. Since discharge, seven of the unmarried women have had children.

Effectiveness of Rehabilitation

The majority of these discharged women, in spite of a wide diversity of problems, are living and working outside the Fountain. The hospital has always been willing to take back any of these discharged patients if they were in any difficulty, although the first aim was to help them to remain in the community. One can hardly compare groups of successful and unsuccessful patients when the latter contains only 3 subjects. One of these returned from a mental hospital to be nearer her home, another's lodging arrangements broke down, but she retained her work, and a third is very emotionally unbalanced. The only factor all three have in common is that they all have relatives who take a sporadic interest in them rather than no relatives. The patients have been divided by the author into four groups. Group I includes those who are successful in their work and personal relations at home or in their lodgings; these patients do not need help in finding either work or lodgings and it is thought that even if they lose either, they will not need help in the future. Group II may need help with either work or living accommodation, although they have managed or might be expected to manage either one or the other. Group III are managing in the present circumstances, but if their parents died, or the special post which suits them was not available, some help with both work or occupation and living accommodation will probably be needed to keep them in the community. These women are more likely to need hostel accommodation at some time in their lives. Group IV contains the "lost", "don't know", and dead cases. The majority of lost cases probably belong in the most successful category; a number are known to be working although not enough is known about them to place them under any of the "known" headings.

Table XI

		No.	Percentage
Group I	Most successful and need least help	123	61·5
Group II	Might need help with either work or accommodation	17	8·5
Group III	Might need help with both work and accommodation	29	14·5
Group IV	Lost and not known, and dead cases	31	15·5

Thus 46 (Groups II and III) out of 169 (or 27 per cent.), may need help from the Fountain Hospital's social worker or the community social services when and if the present arrangements cease. These figures are only a rough estimate and might vary with the national level of unemployment, but it is probably true to say that only a third required more than friendly interest after the first few years.

Personality and Social Adequacy

It was hoped that some useful predictive knowledge might be gained by comparing the personality descriptions given to Group I on entering an institution with those in Groups II and III.

TABLE XII

Personality Description	Group I	Group II and III	Percentage Frequency in Group II and III
A. Social Defects:			
Immoral	26	4	13
Beyond control	5	1	16
Bad-tempered	27	7	21
Dishonest	11	3	21
B. Other Defects or No Defects:			
No defect mentioned	10	3	23
Immature	13	5	28
Emotionally unstable	28	11	28
Moody, obstinate, sullen, slovenly, apathetic	15	6	29
Aggressive	2	1	33
Personality not known	4	2	33
Inhibited	4	3	43
C. Psychiatric Defects:			
Paranoid	5	4	44
Depressive	15	13	46
Hysterical	9	8	47
Schizophrenic or schizoid	5	6	55
Obsessional	1	3	75
Psychotic (1 in Group IV)	0	0	0
Total number of descriptions	180	80	Mean 31

These terms taken from the case sheets and given in Table VI are often lay descriptions and should not be taken as a professional diagnosis. However, when they are arranged in order of the frequency in which they are found, in Groups II and III (the less successful groups) it appears that there is a continuum leading from a group with social defects of personality, through a mixed group to those with psychiatric defects. Those women described as having a psychiatric defect appear significantly more often in Groups II and III ($\chi^2=9\cdot1$, $p<0\cdot01$). The numbers given in Table XII refer to the number of times a term is used. The χ^2 however is worked out on the number of women who were or were not described as having a psychiatric syndrome. There is also a tendency which is just below the 0·05 level of significance for those who are described as having a social defect to be found more often in Group I (the more successful group) $\chi^2=3\cdot72$.

It appears from the value of χ^2 and the percentage frequencies that women who are described on admission as having social defects of the kind enumerated in Table XII under A have a rather better prediction of future success or complete independence than those who are described as having psychiatric symptoms. It should be pointed out that the whole concept of "more" or "less" successful is only tentative and that, had those with psychiatric symptoms gone to a mental hospital, the outcome might have been different.

Intelligence is obviously of importance in individual cases, but in this survey those with an I.Q. over 80 are not found any more frequently among the more successful ($\chi^2=0\cdot47$), and there is no proved relationship between higher intelligence and psychiatric traits in these patients. The distribution of intelligence is shown in Table XIII.

TABLE XIII

Distribution of Intelligence

I.Q.	80 plus	50–79	I.Q. Not Known	Total
Group I	60	31	32	123
Group II and III	25	18	3	46
Group IV	9	3	19	31
Total	94	52	54	200

There are a large number of "not known" cases in Group I, but even if these all had an I.Q. over 80, there would still not be a significant relationship.

PRESENT PERSONALITY

On entering an institution some 150 (75 per cent.) of these patients were considered to be emotionally disturbed. Of the 17 who are not now working, 6 with I.Q.s below 76 are not emotionally disturbed, leaving 11 whose disturbance is such that they cannot earn their own living. They are in fairly sheltered surroundings, in mental hospitals, or with relatives, and it is thought they would not be capable of living on their own and supporting themselves. Thus the emotional disturbance which was considered serious enough to stop them earning their own living seems to have declined from over 75 per cent. to less than 6 per cent. There are, however, a number living and working in the community who still find difficulty in relations with people and their work. Craft (1958) found similar figures in his survey of "Cornish defectives living in the community". He states that "of 100 surveyed, 6 patients were considered to be disabled by mental disorder" and "this finding supports the view that mental disorder is part cause of certification and admission to hospital among the dull".

DISCUSSION AND CONCLUSIONS

One of the main questions that must be asked is whether the original certification of these 200 women and their subsequent years in institutions have been beneficial or necessary, and, if not, how this could have been avoided. As the majority of patients came as adolescents and are now middle-aged, one is assessing and discussing the measures taken nearly twenty years ago of dealing with a problem that had fewer answers then than it has now. In many cases the use of the Mental Deficiency Acts appeared to be the only way of helping a girl. About three-quarters of the "feebleminded" patients who came to this hospital were later discharged, so that it seems logical to re-orientate some institutions from long-term custodial care to short-term training homes or hostels. Since the majority of patients admitted lack parents and homes, the success of their rehabilitation will, to a great extent, depend on the ability of the social worker to provide substitutes for these. A considerable number might avoid going to institutions altogether if enough open hostels were provided for them.

The discharged women do not appear to be engaged in anti-social activities, nor are they a great burden on the community. There is an acute shortage of beds in mental deficiency hospitals at the moment and the pressure on the services can be greatly reduced by the discharge of women who are capable of managing their own lives. To predict those who are so capable is not easy and an element of chance remains. This can be substantially reduced by

maintaining good relations with the patients after they have left, so that they will return for help and advice if they are in difficulties, and by providing social workers to assist with these difficulties. At the Fountain Hospital one of the social workers deals with the after-care of all the adult patients in addition to other duties.

A similar conclusion to that made by Craft (1958) can be drawn from these patients—that for high-grade persons a diagnosis of mental defect applies principally to the young and has a good prognosis. It also seems likely that a very deprived "feebleminded" adolescent can be expected to improve considerably in behaviour and personality as well as in intelligence quotient.

The discharge and the success rate at this hospital appears to be higher than that usually reported from other hospitals. This may be due to a number of reasons—firstly the intelligence of the women may have been higher than elsewhere and their emotional problems less severe; however, the majority originally came from other institutions and did not seem lacking in social problems. Secondly, the policy of allowing discharged patients to come back to the hostel on an informal basis may have helped. These informal admissions tend to work as a safety valve in the same way as any girl might stay at home between different jobs. One of the few features that are found universally among these discharged patients is the lack of a place to which they can return when things become difficult. Thirdly, competent social help was available promptly for all the discharged patients and this may well have made a considerable difference to the success rate.

There is some evidence that those patients with psychotic traits, although suitable for discharge, need more help than those who have transgressed the social code. This may merely reflect the fact that a more positive, aggressive type of personality needs less help than a timid, dependent type. However, it was in the past just these "bad-tempered", "immoral" and "dishonest" patients who constantly rebelled against institutional life and were considered most undesirable and unsuitable for licence by the hospital authorities.

Summary

The purpose of this survey was to assess the past history and intellectual ability of all the adult feebleminded women discharged from this hospital and to make an interim report on the progress of their rehabilitation. It was found that the 200 women discharged by February, 1958 represented 70 per cent. of all admissions with an intelligence quotient over 50. The average age of certification for the discharged women was 22 and the average age at discharge was 35; they have now been living in the community for an average of 5 years. The average I.Q. of the 123 who were tested was 81 on the Wechsler-Bellevue Intelligence Scale. Only 11 per cent. of those tested had an I.Q. below 70. Their past history showed large numbers having physical handicaps, being illegitimate, losing their parents or having mentally disturbed parents. The cause of certification was investigated. It was found that 25 per cent. were certified mainly because of their illegitimate child. The lack of anyone to take responsibility for them in their late teens and early twenties was a very frequent factor. Seventy-five per cent. were stated on admission to have some kind of personality defect. Two patients have been re-certified; one of these went to another institution and has since been discharged and the other is working on daily licence. Contact has been maintained with 171 of the 200 women. About 20 have returned to the hospital for short periods. Roughly a third each

are living independently, are living in a resident post, or are living with relatives. Of those known, only 10 per cent. are not working or housewives, 46 are married; 70 of 200 have had 160 children. Since discharge, seven of the unmarried women have had children.

It is considered that roughly a third of the group need the social worker's help after the first few years.

The results seem to suggest that those who need least help are those described as immoral, beyond control, dishonest and bad-tempered; whilst those who need more help are those described as "inhibited", "hysterical", or those with psychotic features. Three-quarters were described as emotionally disturbed on admission; now there are less than 6 per cent. whose disturbance is such that they cannot earn their own living, although a number still find difficulty in their relations with people, and their work.

The material presented in this paper supports the view that the majority of those classed as "feeble-minded" in the past, and whose difficulties are in effect more social than intellectual, can be successfully re-established in the community.

ACKNOWLEDGMENTS

This is a description of the work of rehabilitation carried out by Dr. L. T. Hilliard, Miss M. Kerry, Mrs. L. Mundy and Dr. C. Williams with the help of the South Side Home nursing staff under Sister Trinder. I should like to thank them for their co-operation and advice in recording the results of their work. I should also like to thank Dr. B. H. Kirman, Dr. N. O'Connor, Dr. J. Stern and Dr. M. Woodward for reading and commenting on this paper and Miss N. Dickinson, Medical Records Officer, and her staff for their help.

REFERENCES

BRANDON, M. W. G., "The intellectual and social status of children of mental defectives", *J. Ment. Sci.*, 1957, **103**, 710–38.

CHARLES, D. C., "Ability and accomplishment of persons earlier judged mentally deficient", *Genet. Psychol. Monogr.*, 1953, **47**.

CLARKE, A. D. B., and CLARKE, A. M., "Cognitive changes in the feeble-minded", *Brit. J. Psychol.*, 1954, **45**, 173.

Iidem, *Mental Deficiency: the Changing Outlook*, 1958. London: Methuen.

CRAFT, M., "Mental disorder in the defective under community care", *Mental Health*, 1958, **17**, 3, 95.

Idem, *Mental Disorder in the Defective. Prognostic factors assessed by a ten-year follow-up*. 1959. (To appear.)

HILLIARD, L. T., "Mental deficiency aspects", *Royal Soc. of Health J.*, 1958, Vol. 78, No. 4.

Idem, and KIRMAN, B. H., *Mental Deficiency*, 1957. London: Churchill.

JONES, H. E., "The environment and mental development", L. Carmichael (ed.), *Child Psychology*, 1946. London: Chapman & Hall.

MUNDY, L., "Environmental influences in intellectual function as measured by intelligence tests", 1955. University of London unpublished M.Sc. Thesis.

Idem, and MAXWELL, A. E., "Assessment of the feeble minded", *Brit. J. Med. Psychol.*, 1958, **31**, 201.

O'CONNOR, N., and TIZARD, J., "A survey of patients in twelve mental deficiency institutions", *Brit. med. J.*, 1954, *ii*, 16–18.

Iidem, *The Social Problem of Mental Deficiency*, 1956. London: Pergamon.

SAENGER, G., *The Adjustment of Severely Retarded Adults in the Community*, 1957. New York University.

TIZARD, J., and O'CONNOR, N., "The employability of high grade mental defectives", I and II, *Amer. J. ment. Def.*, 1949–50, **54**, 4 and 5, 19.

APPENDIX I

A composite picture of the typical case history which is built up as one reads through the case papers is given below:

A teenager is before the authorities. She has a father who is unstable, her mother died when she was about seven and she was looked after by another relative for a few years and then was in three or four different homes. As the time for her to leave school approached, it was realized that she was going to be a problem. She had no proper home or person who was responsible for her. She has temper tantrums and is always seeking affection. She has had a

number of changes of school and she is educationally backward with an appalling lack of arithmetical knowledge. She is short-sighted and has flat feet. The problem she presents is shelved for a few years by sending her to a training home, but she never settles there. She then begins to take an interest in boys, so it is decided that she must be certified as she will get "into trouble". The medical officer who certifies her considers that she is feeble-minded; he notices that she is unable to say how many halfpennies there are in 3s. 4½d. and does not know the name of three counties. She is not seen by a psychologist. When she is ultimately tested, it is found that she has an I.Q. of 84 and that she is an immature and unstable adolescent with a strong distrust of authority and no one she can turn to in place of her family. This girl spends 8 years in other institutions where she is not considered suitable for licence and then comes to the Fountain as a "working patient". This is, of course, an average picture with all the faults which come from telescoping information.

https://doi.org/10.1192/bjp.106.442.355 Published online by Cambridge University Press