"NEW LAMPS FOR OLD"*

By

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FIFTY-ONE years have elapsed since the Report of the Royal Commission on the Care and Control of the Feeble-minded was published and paved the way for the Mental Deficiency Act of 1913. Since that time two developments have taken place. On the one hand the administrative procedures for dealing with defectives on the basis of the Act and its amendments have been clearly defined and formalized. On the other there has been a continuous development and expansion of our social and welfare services. These developments, which should have been complementary in their aims, have in fact often proved conflicting in effect, because mental deficiency until very recently was bound to outmoded procedures which were designed to segregate the defective from the community rather than to integrate him with it, and give him the opportunities for re-socialization which our modern welfare services afford. The original belief that a hereditary neuropathic diathesis lay at the root of most of our social ills and would sooner or later lead to national degeneracy has been replaced by scientific genetic studies, and by medical research into the aetiology of the condition, and the associated problems involved in the training and employability of the defective. Increasing professional and public recognition of the inherent faults of existing mental deficiency legislation led to the setting up of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency which published its report in May, 1957, and this in its turn has prepared the way for the Mental Health Bill which is at present in the final stages of its passage through Parliament.

The radical changes in the law relating to mental deficiency envisaged in the new Bill are a reflection of the changes that have occurred in our outlook in recent years. Fifty years ago it was believed that 80 per cent. of all mental defect was due to the operation of hereditary factors and would occur even in a favourable environment (Tredgold, 1908). So strongly was this view held in certain quarters that when the draft of the first Mental Deficiency Bill was presented to Parliament in 1912 it contained a clause which sought to prohibit the marriage of any person considered to be a mental defective. This clause provoked such strong opposition that the Government withdrew the Bill at the end of the parliamentary session, and submitted a modified Act the following year. The publication by Penrose of the results of the Colchester Survey in 1938, emphasized the importance of environmental and social factors in every case of backwardness. The challenge presented by this report to what had previously been regarded as a fundamental principle did much to arouse the interest of voluntary bodies in the problem, and has encouraged in recent

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years an extension of scientific research, into the causation, prevention and treatment of mental defect. In a limited number of specific conditions it has been shown that medical treatment and improved social conditions are capable of correcting many of the effects of faulty heredity.

For over thirty years the view expressed by Painter (1923) that the number of chromosomes in man was forty-eight was generally accepted. The recent introduction of new techniques by various workers (Tjio and Levan, 1956; Ford and Hamerton, 1956) involving the use of hypotonic saline or citrate solutions in tissue cultures to expand the cells and separate the chromosomes, the use of colchicine to arrest chromosome division before completion, improvements in the Feulgen stain, and the use of the "squash" technique were all required before significant improvement could be obtained in mammalian chromosome counts. The first triumph for the new methods was the demonstration that man has forty-six chromosomes, not forty-eight as was formerly believed.

The second advance has been the development by Ford and his colleagues (1956) of the use of short-term cultures of sternal marrow, which has resulted in the elimination of the chromosomal anomalies which are likely to occur in tissue cultures which have been maintained for any length of time. This cumulative series of improvements has resulted in the demonstration of significant deviations from the standard chromosome complement in certain clinical conditions. The methods evolved by Ford and his team at Harwell (1958) have enabled Penrose (1959) and his colleagues to demonstrate in a mixed case of mongolism and the Klinefelter syndrome the presence of two additional chromosomes, one an acrocentric autosome, and the other a Y chromosome. This is probably the first occasion on which the presence of supernumerary chromosomes in a human cell has been demonstrated, although twenty-five years ago, Penrose (1934) postulated on an inferential basis that mongolism was due to a genetic abnormality.

Extending the work at Harwell and using the same methods Court Brown and his colleagues in Edinburgh (1959) have investigated the chromosome morphology in six cases of mongolism, and in each they have demonstrated the existence of an additional chromosome which they regard as an acrocentric autosome in the smallest size range. The implications of these findings are many, some are potentially important, and the investigation continues. In this respect it is interesting that in tuberous sclerosis, where the condition has been generally accepted as being due to the inheritance of an extra chromosome, no such abnormality has so far been found by the Edinburgh team.

The results of several social surveys have established the fact that the majority of the feeble-minded are found in families that are significantly above the average in size and with fathers who are employed in the lowest occupational grades. On the other hand the brightest children were found in families below the average in size and with parents in the professional and executive classes (Lewis, 1929; Jones, 1934; Roberts, 1935). The inverse relationship of intelligence to fertility led to the assumption that genes causing low intelligence were undergoing a progressive increase, while the complementary genes associated with high intelligence and low family size were tending to die out. In these circumstances it was considered almost inevitable that a gradual lowering of the national level of intelligence would result. The expected order of decline was estimated as being of the nature of two points of I.Q. in each generation (Burt, 1946). So far there has been no direct evidence of declining intelligence in this country. The results of two Scottish surveys of school children in similar age

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groups in 1932 and 1947 (Scottish Council for Research in Education, 1949), supports the view that there has been no falling off in the test performance of children in the fifteen year interval between the two surveys and there may in fact have been a slight improvement. In recent years an increase in the stature and weight of children, and a declining infantile mortality rate have been reported in many countries and have been attributed to improved nutrition and better hygiene. It has been reported by various workers that intelligence, stature and health are all positively correlated (Ashby and Stewart, 1933; Penrose, 1949) and it would appear to be a reasonable expectation that the improved social conditions which have brought about a progressive improvement in the general health of the population will eventually be reflected in an improvement in its mental health and eugenic endowment.

Whilst our views on the nature and definition of mental defect have been considerably modified in recent years, so also have our views on the best methods to be adopted in mitigating its social and economic consequences particularly with regard to the education and training of the imbecile. In Scotland at present the education of the imbecile child is undertaken at Occupation Centres administered by the Education Committees, and in England at Special Training Centres administered by the Health Authorities, as day pupils. In the past it has been customary to exclude from these centres children at the lower level of the imbecile grade where speech and body balance are poorly developed. Experience has shown however that many children formerly regarded as hopelessly retarded make a good response to training at such centres provided it is started in the early years of life. It is now generally accepted that the apparent degree of mental defect in a young imbecile gives no true indication of the degree of improvement that can result from training and as a result many children who were formerly excluded now attend and benefit from training as day pupils. In many cases training in a junior occupation centre may be continued with advantage after the defective has attained the age of sixteen years. Senior occupation centres in Scotland are at present provided and administered by the local health authorities. It would appear desirable that in order to secure greater integration and continuity of training the dual control which at present exists in Scotland should be brought to an end and that both junior and senior occupation centres should be provided by the local health authority; as has been done successfully in England for many years.

Similarly in the case of the older imbecile a series of recent studies by O'Connor and Claridge (1955) and by Gordon and others (1955) have done much to alter long established beliefs regarding their adaptability and capacity for training. These workers found that with suitable training and appropriate incentives the performance of imbeciles at commercial tasks steadily improved both in respect of speed and complexity of work undertaken over long periods of time. It has been found that under sheltered workshop conditions many are capable of earning a wage that will materially contribute to their maintenance.

With regard to high-grade mental defect a series of studies carried out by the Social Psychiatry Unit of the Medical Research Council (O'Connor and Tizard, 1954) showed that some 58 per cent. of patients in mental deficiency hospitals in London, Kent and Surrey were classified as feeble-minded. The survey showed that when the feeble-minded patients between the ages of 16 and 30 years were examined by means of a standardized series of tests they returned an average intelligence quotient of 71–74 and that there was a considerable overlap in point of test performance between the high grade defective

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and the dull normal. In regard to stability of behaviour the survey showed only a low incidence of gross departure from accepted standards and that while many showed milder degrees of neurotic behaviour the investigators concluded that it was better to give such individuals a chance of rehabilitation outwith a mental deficiency hospital, rather than to continue detention on the grounds of their neuroticism. These results suggest the possibility that, in the case of high grade defectives of both sexes, after a preliminary period of examination and observation in a mental deficiency hospital, many of the more intelligent would be best treated by a period of short-term rehabilitation in small hostels, or in the general community with the supervision and support of the social agencies of the Local Authority or of the voluntary associations.

It was, therefore, to a professional and public opinion conscious of the need for a closer integration of all the social services available for dealing with the problem of mental deficiency and with a more optimistic outlook regarding its effects that the Mental Health Bill, which applies only to England and Wales at present, was introduced this year. It is a courageous and enlightened attempt to bring the arrangements for dealing with all forms of mental abnormality into line with the existing arrangements for dealing with physical illness, and to secure for the mentally handicapped a general re-orientation towards community care and away from segregation in large institutions. So far as the mentally handicapped are concerned the principle of the informal admission to hospital without power of detention, compulsory detention in a limited number of cases and for limited periods of time with a right of appeal against such detention, the increased responsibility of the local authorities for community care and after-care, are all matters the need for which has long been recognized and which will receive general acceptance. In Scotland, a Mental Health Bill is at present being drafted which in its broad outline will generally conform to the English measure, but is likely to contain several important modifications if the recommendations of the Health Services Council (1959) are accepted by the Secretary of State for Scotland.

We, in Scotland, have been singularly free from the allegation of the existence of many cases of wrongful certification, wrongful detention, and lack of adequate safeguards with which the Royal Commission was confronted. This is due in no small measure to our traditional respect for the integrity of our legal system, and those responsible for its administration. We do not deal with amateurs, and have long believed that an individual should only be deprived of his liberty on the grounds of mental abnormality by a professional jurist, on account of his qualifications to assess the validity of a judicial application. In practice where compulsory detention has been considered necessary or desirable this has been effected by presenting a petition to a Sheriff for a Judicial Order. In cases where objections are raised to the granting of such an Order the Sheriff reaches a decision only after both sides have been heard. Similarly in Scotland when an Order for the continued detention of a patient in an Institution or under Guardianship is made the Board of Control have a statutory duty to inform both the patient and his relatives that such an Order has been made, and at the same time to inform both parties of their right of appeal to a Sheriff against the granting of such an Order, if they wish to do so. We believe that, not only have these measures been effective in practice, and have been administered with conspicuous fairness and impartiality; but also that they have adequately fulfilled that other important prerequisite of good legislation, that they are obviously fair and impartial in their intent and design. There are many who believe that our existing legal machinery both for the granting of Orders and for

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the right to appeal against them is one of the ornaments of the existing Mental Deficiency Acts and one that we are anxiously concerned to retain.

In England it is now generally accepted that the Board of Control will be abolished, and its remaining functions absorbed by the Ministry of Health. We, in Scotland, take a different view. We believe that some form of supervision of our mental hospitals will always be necessary, and that such supervision can best be given as at present by the specific appointment of medical men and women for this purpose who have had a wide experience of all forms of mental illness. We also believe that the Board of Control has a valuable function to fulfil as an authoritative and accessible tribunal for the investigation of complaints by patients or their relatives, and that in the performance of these duties it provides a strong safeguard not only for the interests of the patient but also for those responsible for their care. There is a large body of informed opinion that believes that the Board of Control has still a valuable part to play in the administration of the mental health services and that it should be retained and strengthened. It is probable that in the future the Board will be concerned mainly with patients who are detained compulsorily and that it will retain a residual right of discharge in such cases. It is also felt that it should retain the right of access to any person either in hospital or elsewhere, who they have reason to believe is unable to look after his own interests, or is improperly treated.

The radical nature of the proposed legislative changes will almost certainly create initial difficulties; but we are by nature a nation of empiricists and we shall doubtless in this situation as in the past continue to deal with specific difficulties as they arise. Legislative changes will not of themselves greatly alter the present situation; but the combination of increasing scientific knowledge and enlightened legislation does present us with an opportunity, if wisely used, to evolve a mental health service, that could prove to be one of the great social achievements of our time.

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