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President,

1933–34.

https://doi.org/10.1192/bjp.79.327.563 Published online by Cambridge University Press

THE

JOURNAL OF MENTAL SCIENCE

[*Published by Authority of the Royal Medico-Psychological Association.*]

No. 327 [NEW SERIES No. 291.] OCTOBER, 1933. VOL. LXXIX

Part I.—Original Articles.

MENTAL DEFICIENCY.

THE PRESIDENTIAL ADDRESS AT THE NINETY-SECOND ANNUAL MEETING OF THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION, HELD AT COLCHESTER, JULY 5, 1933.

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I AM intensely proud of the very great honour you have done me in electing me President of the Association for the ensuing year. I believe I am right in saying that this is the second time only in the history of the Association that you have chosen as your President one whose work in life has been entirely connected with mental deficiency, Dr. Fletcher Beach in 1900 being the first. In taking "Mental Deficiency" as the subject of my address, therefore, I am comforted by the reflection that I have a fresh subject about which I can roam at will without the fear which I understand generally gnaws at the vitals of Presidents lest they should choose a theme that has already been dealt with in past addresses.

To France undoubtedly belongs the honour of having first attempted to do something for the mentally defective. Séguin, a pupil of Itard, believed that idiocy was curable, and founded in Paris in 1837 the first school for the specific purpose of educating idiots. He called his method of treatment the physiological method and laid down that one of the first principles in treatment was to supply the deficiencies of the muscular apparatus. The training began with the overcoming of muscular incapacities.

I think if I had wanted another title for my address, I might have headed it "The Wheel Always Comes Full Circle". Over and over again in the case of defectives during the past 100 years it has happened that methods and

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ideas thought out quite early in the movement and later discarded and forgotten, have been rediscovered and hailed as new ideas. Séguin's methods of 100 years ago are the basic principles of training in the occupation centres of to-day. In all classes for the lower grade defective children it is now recognized that the first necessity is to awaken the senses, educate the larger muscles of the body and infuse vitality, and that only after success with these points can we hope for success with finer movements and the training of the higher centres.

When I first came to the Royal Institution at Colchester, 28 years ago, the aim of school classes was that all children must be taught to read and write. A whole class of lower grade imbeciles would sit day after day in front of their slates trying to copy round O's. If they succeeded they were with great triumph promoted to the copying of a's. Few got beyond that to the capital " A ". Now the teaching of letters and writing for this type of child has been quite given up.

The early years of Queen Victoria's reign were full of philanthropic schemes, and amongst the foremost philanthropists of the time was Dr. Andrew Reed, who founded not only the first two asylums for idiots, but also several orphan asylums and the Royal Hospital for Incurables.

Articles appeared in *Chambers' Journal* in January, 1847, containing a description of Séguin's work in Paris. These were read by a Mrs. Plumbe, who took them to Dr. Andrew Reed, and he spent his summer holiday abroad studying the matter.

Other people were interested by him, a committee was formed and a meeting held at the Mansion House in October, 1847. It was decided to found an " Asylum for Idiots ", and the first patients were admitted in April, 1848, to a house at Highgate.

This house soon proved too small, and in 1850 the original buildings of the present Royal Institution in Colchester were taken over. These had been erected for a railway hotel. In the course of the next few years two farm-houses in the neighbourhood of Colchester were rented and used as branches, ancillary premises or colonies. The prevailing idea in those days, however, was to concentrate an institution in one place, and great efforts were therefore made to collect sufficient money to build on one spot a " Model Asylum " and to scrap these ancillary premises. These efforts succeeded, the asylum was built at Earlswood, near Redhill, and in 1858 the last of the then patients at Colchester were transferred to Earlswood.

When the patients were removed from Colchester, Dr. Reed began the task of founding an asylum for idiots for the four eastern counties only, and in 1859 the present institution at Colchester was opened for 100 idiots from Essex, Suffolk, Norfolk and Cambridge. The first Superintendent was a layman, a Mr. Millard, who was one of the original members of Dr. Reed's first committee in 1847. For nearly 30 years the numbers remained at 100.

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In 1864 my father started work at the institution, where he remained till he died, 49 years later. I need not mention all the extensions that have taken place. They began in 1883 through the generosity of Mr. William Birkbeck of Norwich, and have been almost continuous since that date.

This asylum, together with the one at Earlswood, and the three later ones at Lancaster, Starcross and Birmingham, were all commenced, built, extended and maintained by the charitable subscriptions of philanthropic people. Apart from certain asylums, technically, I believe, special workhouses, set aside by the Metropolitan Asylums Board, these charitable institutions remained for many years the only institutions in England where defectives could be specially trained and cared for. Without wishing to appear presumptuous, I suggest that one of the secrets of the success of social work in England in the past has been that in the first instance nearly every great cause has been commenced by the voluntary effort of people who, stirred by some great evil, or by some great need, put their shoulders to the wheel and their hands in their pockets to do what they could to help their fellows. I think this fact is too little recognized nowadays. It has generally been the case that the State has only given help after years of voluntary effort have pointed the way.

Though special day schools were permitted by the Act of 1899, it was not until the passing of the Mental Deficiency Act in 1913 that the local authorities were empowered to build their own institutions for defectives and to contract with existing institutions to take their cases on payment. Though this is 20 years ago, the Royal Institution at Colchester still has a charitable income of nearly £10,000 a year and maintains about 200 patients by its charitable funds. Though the Institution has in addition provided nearly 1,300 beds for patients sent and paid for by the local authorities, and though it has an endowment fund of £50,000 and nearly 400 acres of land, not a single bed, not a portion of any one of the buildings or land now in use has been provided by any local or statutory authority. All has been provided by the directors of the institution out of charitable funds, and in addition, during later years, out of certain profits made by the reception of paying cases.

Just before Christmas last, however, after years of planning and negotiation, a further extension for 444 patients was commenced on a site a few hundred yards from the existing Institution. The money for this extension is being found by the local authorities of Essex, Suffolk and Cambridge, and when these buildings are opened these authorities will have proportionate representation on the governing body. This extension forms the first section of a much larger plan which will eventually add 1,100 or 1,200 beds and bring the total number up to about 2,400.

I mention this extension because I believe it is the first time that several authorities under the Mental Deficiency Act have joined together with an institution which is still a voluntary one to build and furnish a large extension. It will cost about £180,000.

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No doubt in years to come, and as the local authorities provide further extensions at their own expense, the governing body of the institution will gradually lose its present distinctive voluntary character, the charitable subscriptions will gradually diminish and eventually, I suppose, the institution will be absorbed by the local authorities. At present that day seems a distant one, as I believe these authorities recognize the valuable and distinctive character and attributes possessed by a voluntary institution and are glad to refrain from doing anything that may imperil its existence.

You will have noticed that I have so far spoken of the "idiot" and "asylums for idiots". This does not mean that the first institutions dealt only with low-grade cases. The word "idiot" was then the only legal term, but it included all the grades of mental defect we now recognize. Dr. Duncan, who was an F.R.S. and the first medical officer of the Institution at Colchester, in his first Annual Report, divided the objects of the charity into three classes, idiots, imbeciles and simpletons. The latter word he used for the highest grade, and with him the term "feeble-minded" covered all three grades of defect, as it now does in the United States. His definitions of the three terms could not be bettered to-day, and he specially laid it down that the simpletons were to be distinguished from the backward and ill-taught The name "Asylum for Idiots" was then a title to be proud of; it is only latterly that it has become a term of reproach.

I admit that the proportion of high grades to the medium and lower grades was not then so high as it has been since the passing of the Mental Deficiency Act; yet there were undoubtedly many of the highest grade of feeble-minded received under the old term "idiot". This is proved by the fact that five of the earlier pupils admitted were at the end of their term of election engaged on the staff of the asylum, and as early as 1860 five pupils were able to make panelled doors.

In those early days the idiot asylums were under the Lunacy Acts. In course of time people become so impressed with the absurdity of having to use all the formalities of the Lunacy Acts if a parent wished to send a defective child to an institution for special education, that in 1886 an Act labelled the Idiots' Act was passed. It was under this Act that the voluntary asylums for defectives worked until 1914. It legalized the use of the word "imbecile" for the highest grade of defect, and allowed a defective to be sent to an institution on one medical certificate and a statement by the parent or guardian. This very simple form is still fortunately retained in the Mental Deficiency Act for private and charitable cases, except that an additional medical certificate is now required. In the drafting of the Idiots' Act the promoters of the bill desired to use the term "mental defective" instead of "imbecile", but could not get it through Parliament. It was presumably too advanced for those days.

It was not till 1914, that under the Mental Deficiency Act, the term

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"feeble-minded" was legalized to cover once again the highest grades of defect, and now it, in its turn, has become a word of reproach.

The aim of all the early asylums for defectives, as of Séguin in Paris, was to cure the defective. There was then no intention of lifelong care. They commenced as schools, with schoolmasters and industrial trainers. Their aim was education. In the words of our first report "to try by the skilful and earnest application of the best means in his education to prepare him as far as possible for the duties and enjoyments of life". It was felt that if only the right methods of teaching could be found the great majority of the patients could be so far improved that they would be able to return to the world. The first asylums taught almost all the trades which can be found nowadays in the most modern institution. It was only after years of effort and experience that our fathers came to the melancholy conclusion that though great improvement was possible, yet lifelong care of some kind would be necessary for large numbers of defectives.

Following on this conclusion, public opinion went, as usual, to the opposite extreme, and there developed in England as well as in the States what has been well named by Dr. Stanley Davies of New York "the alarmist period". The discovery of our inability to cure many defectives admitted to the institutions and to the special schools was, no doubt, the first cause of this alarm, but it was greatly increased by the invention of intelligence tests. Methods of testing the intelligence by means of standardized tests were developed in profusion and used with that enthusiasm which most of us bring to new developments. Tests were relied on as the ultimate and decisive factor on the question of feeble-mindedness. Below a certain mental age which at first was put at the very high standard of twelve years, all were supposed to be defective, and we evolved a pretty scheme by which defectives with a mental age below 4 years were labelled idiots, from 4 to 8 years imbeciles, and from 8 to 12 years feeble-minded. No one now believes in that.

I think it may fairly be said that in England we never went quite so far in this direction as some authorities in the United States, and it soon became apparent that if these standards were adopted we should be compelled to label perhaps one-third of the population as feeble-minded, which was absurd. Statistics were also published to show that the great majority of women in refuges were mentally defective, and that a large percentage of the prison population was feeble-minded. Nowadays, I believe medical officers in the prison service tell us it needs more thàn the average amount of brains to earn a living by crime.

Emphasis upon eugenics and heredity studies all seemed to teach the same alarmist doctrine. Opinion on the flood of children of a poor type, supposed to be brought into the world by defectives, has been largely formed not on reliable figures, but on collections of individual family histories, more especially those well-known efforts from the United States, the Kallikak family and the

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Jukes family. These seem to prove—like a lesson from a copy-book—the inevitable downfall of the human race, and the swamping of the good stock and the average normal person by the defective and incompetent.

Nowadays, it is recognized that the compilation of these family histories was hopelessly unscientific, but the effect of this propaganda was to create a deep feeling of alarm. At all costs the propagation of defectives must be prevented and lifelong care by segregation in institutions was thought to be the only remedy. The institutions which began as schools, electing their pupils for a limited period only, were urged to retain them for life.

Even yet I am not quite sure that this alarmist period in the treatment of defectives is over. At times you may be tempted to believe that the question is still acute. You may even be stampeded into thinking that if something is not done to prevent defectives propagating, the world will be overrun by them, and the few of us able to work will have all our earnings absorbed by the hopeless task of maintaining the inefficient and the defective. Though I do not suppose that anyone nowadays would repeat the assertion, yet it is less than ten years ago that a well-known society, established to improve the race, published a pamphlet which said that " if all mental defectives could be prevented from having children, the number of defectives in the country would be halved in about three generations ". To anyone who has everyday personal experience of defectives and their families, that is a statement which seems to have no foundation whatever in any knowledge we at present possess. The very great majority of defectives are not the children of defectives.

The report of the Wood Committee, of which I had the honour to be a member, has often been misquoted to give substance to these alarmist views. It has been said that this Committee stated that the number of defectives had doubled in the last twenty years. The Wood Committee said nothing of the kind. It said that the number of defectives ascertained by Dr. Lewis in the areas he investigated was twice as high as the number found in other areas by the investigators of the Royal Commission on the Feeble-minded twenty years previously. That is an entirely different proposition and does not of itself imply any increase at all. It may, and in my opinion does, depend almost entirely on the more thorough nature of the later investigation. At the time of the Royal Commission our ideas of what constituted mental deficiency were nothing like so definite as they are now. The great majority of the cases we now call feeble-minded would not have been certified then. They existed just the same. In those days little interest was taken in the question. There was no duty imposed on a local authority to find out the number of defectives in its area, and there was no stimulus to do it. There were no voluntary associations for mental welfare, the number of special schools for defectives was small and there was no incentive for the teachers to report defective children. The

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investigators for the Royal Commission had therefore a difficult task when they set out to ascertain the numbers of defectives in certain areas. Dr. Lewis, on the other hand, found an awakened public interest and conscience quite different to that existing in 1904; he had the benefit of the ascertainment of defectives already carried out by the local authorities under their statutory powers given in 1914, the assistance of voluntary associations and the willing cooperation of the education authorities and the teachers. Is it any wonder that he ascertained double as many defectives as the investigators for the Royal Commission?

My opinion is that while there has certainly been no great increase in the real number of defectives, it is possible there has been a slight increase, due partly to the lowering of infant mortality and to greater longevity of defectives, but I do not believe that defectives are on the average more prolific than normal people of the same social standing, or that their children are necessarily or even often defective.

Defectives in institutions certainly live longer than they did. In the five years before I was appointed here, the death-rate was on the average 7·5% each year. In the last five years it has been 1·4%. If the death-rate had remained at the same figure as before 1905, the number of deaths in this last five years would have been 503, but the actual number of deaths has been 96. The number of institutions in England is scarcely enough, however, to have much effect on the population taken as a whole.

We still, however, get pronouncements from eminent men in other walks of life emphasizing the alarmist view. I cannot help feeling that if these eminent men had made as close a study of mental deficiency as they have of surgery or theology, or even if they had followed recent developments in genetics, their statements would not be quite so dogmatic. I feel, too, that their views may be coloured by a misconception of what mental deficiency really is. Popular opinion looks on it as a pathological entity, a single type of disease. Years ago most of us thought of mental defect in this way as a small, but distinct group of individuals forming more or less a distinct species and differentiated from the normal by a marked divergence in their intellectual and emotional life. The conception of mental defect as a single entity is, I believe, wrong. Mental deficiency is a dozen, twenty or more different things, each with a different cause and therefore a different remedy. In some cases it is due to a definite mischief of which we know the cause, like birth injury, congenital syphilis or some inflammatory condition of the brain like encephalitis, or to an alteration in the internal secretions of some glands. These are the hopeful types of mental defect. We know the causes. We may reasonably hope that by more skilful ante-natal and natal care and greater knowledge of disease processes these types of defect may be largely eliminated.

I do not think that any of us who have made a study of mental deficiency

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would be prepared at the present time to say how much defect is due to those preventable causes, how much, if any, is due to heredity acting alone and how much is due to an inextricable mixture of environment and heredity. Nor should we be prepared to give a firm opinion as to how far, if at all, the brains of the higher grade defectives differ from the normal brain in the same station of life.

In exactly the same way as the earlier books on mental defect contained photographs only of the lower type of case, the obvious idiot, so we have drawn our ideas as to the brain-cells of defectives from histological examination of the brains of idiots and imbeciles. In most of the cases examined the defect was probably due to gross cerebral damage or disease changes. The conclusions almost certainly have no importance for the higher grade cases. An urgent need is the histological examination of the brains of higher grade defectives of different mental ages and their comparison with the brains of supposedly normal people of the same social standing. I doubt if we should find any differences.

We at Colchester are indebted to the far-seeing outlook of the late Sir W. Morley Fletcher and the Medical Research Council who, for the last two and a half years, have given a substantial grant in aid of the Research Department. This grant, together with grants from the Darwin Trustees and the Committee of the Institution, has enabled us to maintain a medical man as head of the Research Department, and now three assistants. We believe that research will bring out important and vital facts on these questions of heredity and environment. Without committing the Department in any way, my own view is that a much smaller proportion of mental defect is due to the family hereditary type than was formerly thought to be the case. It is more satisfying of course to blame poor old heredity. Then we can feel we are not responsible. If we admitted mental defect was in many instances due to environment, our consciences might make us uncomfortable.

I have been especially struck with two points. One is the great effect of environment on the production of *certified* defectives. I can point out case after case in which I believe the early environment has been the real cause of the defective being certified. If the environment had been better the defective would not have been certified, but would probably have led a blameless, hard-working, self-supporting life, though in perhaps a lowly sphere.

The legal definitions of a defective are social in character. They do not depend on mental age or specific tests or educational capacity, but on the social capacity to live in the world to which they belong. These definitions are admittedly not scientific, but they are practical, suited to the world as it is, and they work.

It is a truism to say that civilization produces defectives by making living conditions more difficult and that a person may be regarded as defective in

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a big city and not in a country village. Plenty of people who a thousand years ago were no doubt highly respected members of society would nowadays be called defective. It did not take a lot of intelligence to run round the country and hit another man over the head with an axe; nothing like so much as is needed nowadays to get out of the way of a motor car.

My second point I owe to Dr. Lewis's inspiration, even if he may not agree with all my conclusions. May I say that this paper was written weeks before an article by Dr. Lewis on "Types of Mental Deficiency" appeared in the last number of the *Journal of Mental Science*. I apologize to him for so inadequately following in the direction he has pointed out. I believe that when we have excluded the cases definitely due to disease or injury, there remains a large proportion of defectives who are not pathological in any way. There is no question of a so-called neuropathic inheritance, whatever that may mean, or of "carriers" of defective germ-plasm. They are just ordinary, normal people. If you test the intelligence of large numbers of people in all stations of life and plot out the numbers falling into each mental age in a diagram you get a curve. The curve falls more and more quickly towards the zero-line at each end. The majority will have an average intelligence and will belong close to either side of the centre, the highest part of the curve. The number of those who have superior intelligence decreases more and more rapidly as you get further from the centre. The number of those with inferior intelligence decreases in the same way the further you get below the average. There is no sharp line of demarcation anywhere between the lower intelligences, the average intelligences and the higher intelligences. The curve is a continuous one. You cannot anywhere along it draw a line and say above this line is normality, below it is abnormality. The people whose intelligence falls below the average are just as essential to a curve of intelligence as those whose intelligence falls above the average and just as normal, if not more so. A below-average intelligence is no more abnormal than a below-average height. We do not consider a person an inch or two below the average in height to be abnormal or defective. Why should we consider a person an inch or two below the average in intelligence abnormal? Both are just natural variants. It is as natural to be below average as to be above average.

Life has become more difficult, more complicated as civilization advances, and as mental defect is entirely a social question, increasing numbers of those who fall among the lower sections of the intelligence curve fail to keep up in the race. We expect from them more than they have the capacity to produce. Naturally they fail, and to prevent them acting as grit in the wheels, and for their own protection, we label them defective and certify them. That does not make them pathological or diseased. They are just normal people whose intelligence is a little below the average, but who very often are able to do the so-called menial jobs of the world better than those of higher intelligence. It is especially when you add to this below-average intelligence

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bad home circumstances or a bad or too difficult working environment that you get failure.

It can be argued that if you had omnipotent power and could at one stroke eliminate from the world all those below a certain level of intelligence you would still not eliminate mental defect. Amongst those who remained the average of intelligence would necessarily be raised, but some would still come below this new and higher average point. Owing to the raising of the average, competition would be keener, life would become still more complicated, and those who fell below the new, though higher, average would fail in the struggle, would be unable to manage their affairs according to the prevailing higher standard and would therefore be labelled defective.

If there is any truth in my suggestions, of which I am the worst judge, then it logically follows that do what you will, sterilize whom you will, even follow the example set by one state in America where they brought in a bill recently to sterilize all motor-car thieves immediately on conviction, you will still fail and are bound to fail to eliminate the normal people with somewhat below average intelligence who cannot react successfully to their environment and whom, therefore, we label mentally defective. The only hope for the future lies in tackling the environment—instead of the far less troublesome method of cure by wholesale surgical operations.

In my opinion eugenists fail to distinguish between people of a certain intelligence level who partly, at any rate, because of their environment fail in the world and are labelled defective, and those hundreds of thousands, if not millions, of people who, with exactly the same intelligence, manage to live an ordinary self-supporting life in the world.

I have often wondered what becomes in after life of the school-children diagnosed, and no doubt properly diagnosed, as feeble-minded, when they grow up. No investigation which has ever been carried out can discover amongst the adults of the community anything like the percentage of defectives there should be if all those diagnosed as defective when children proved to be defective when grown up. What happens to them? Presumably they are supporting themselves and living decent lives.

There has just been published in the American journal *Mental Hygiene* (April, 1933) a report on a follow-up of children who were in a special school seventeen years ago. There were 122 of them. It is the report on the lowest group of these which is most illuminating. Seventeen years ago it was judged that 22 had no prospect of becoming self-supporting. Of these 17 are still living, and it is found that 12 of them are entirely self-supporting even in these difficult times. The whole group has had 173 children, and only 3 were diagnosed as defective. The records of the Birmingham Special Schools After-care Committee are of greater value because they deal with much larger numbers. They point the same lesson. In my opinion the alarmist view of mental defect was founded on the mistaken idea that subnormal or

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below-average intelligence is the same thing as certifiable feeble-mindedness. It is not. Certifiable feeble-mindedness is something added to subnormality, namely (excluding the injury and disease types), bad environment. Large numbers of the higher grade defectives would not have been certified if their environment had been good.

If we take this as a text, we have prepared the way for the modern treatment of mental defect. This modern view is absolutely at variance with one of the conclusions of the Report of the Ray Committee, which said that there was no evidence that more than a negligible number of the mentally deficient are improved by treatment. We believe the truth to be exactly the opposite, namely, that the great majority of defectives are very much improved by the training and stabilization they receive in institutions, so that many of them can be sent back into the world to earn their living or with some supervision to be cared for more simply and less expensively than in an institution. The wheel has come full circle. It is this aim, this belief, this return to the faith Séguin preached that is behind all the modern outlook, behind the methods used nowadays in institutions for defectives.

At the present time more than 10% of the patients on the books of the Royal Institution are on licence. Many of them have been on licence for years. Yet each of them was certified and sent to the Institution as in urgent need of institution care, and with the present shortage of beds the need must really have been urgent or they would not have stood a chance of being admitted. Other institutions have obtained even better results.

I admit it places the institution for defectives in the forefront of the fight and possibly the superintendent of such an institution may need to be as efficient as Pooh Bah in the number of appointments and duties he is capable of directing.

The institution of the future should be a flowing lake constantly fed by incoming patients, but just as constantly passing back to the world in several directions and by several different methods many other patients who have been trained and stabilized while under its care. Resocialization is the aim. Spread the available jam of teaching and training over the greatest possible number. It will never be possible to provide a sufficient number of big training institutions to allow of every mental defective in the country being retained permanently. The expense would be prohibitive. The problem is to find the best way in which the central institution can, within the limits of its capacity, give the greatest service. I am not sure that in the future it may not be a matter for reproach that any superintendent should ask his committee for increased accommodation and more beds. He would be told that he was failing at his job, that of resocialization. At present this seems a counsel of perfection, but it may well be the goal for which we should aim.

The instrument by which we can achieve this resocialization is an ever increasing and more effective use of one of the most valuable provisions of the

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Mental Deficiency Act, the power to grant leave of absence or licence to defectives from an institution for just as long as may be necessary. The Act lays down no period after which licence must be determined. It can be renewed from time to time on evidence of good behaviour, I know of many patients who have remained successfully on license for from five to ten years, though the majority of the successful ones get discharged before this time. We owe this idea of prolonged licence chiefly to Dr. Bernstein, of the institution at Rome, U.S.A.

Here again events repeat themselves, and we have come back to a point we started from. I found recently in one of the earliest reports of the Royal Institution that patients who had been improved used, in those days also, to be sent out on licence. The practice, however, seems to have been given up and forgotten.

Dr. Bernstein not only sends many of his patients out on licence; he has, in addition, what he calls "colonies", forming a valuable kind of half-way house. They are often miles from the central institution; they are separate houses or farms from some of which the boys and girls go out to daily work in the neighbourhood; in others they work in the home or on the farm; but in every case more liberty is allowed than in the central institution. They are trying-out places to determine whether or not the defective can stand the increased responsibility and the greater freedom. A certain number fail and have to be returned for a time to the central institution for further stabilization. Others succeed and are then placed out on licence away from the colony.

In England we have copied Dr. Bernstein in this respect also, and many of the larger institutions now have branches or colonies separate from the central institution, where their boys and girls can be tried out, given greater responsibility, gradually resocialized, and got back to the world again. Branches like this have definite advantages and some disadvantages. They allow of better classification of patients than can be obtained even with the modern system of villa building for institutions, but the chief reason for their existence is to permit greater freedom and give more responsibility than is possible in the big institution.

Disadvantages are the greater expense of catering and stores, the greater outlay on staff. These are partly offset by the fact that houses can often be rented, so that there is no outlay for capital expenditure beyond some structural alterations and the furniture.

I would seriously recommend to those of you who find a difficulty in getting funds for capital expenditure the provision of beds by this simple method of renting large houses anywhere in your respective areas and using them as branches or colonies of the central institution. Here, of our 1,500 patients, 570 only are in the central institution. Nearly double that number are in branches or colonies or on licence. We have altogether nine of these branches.

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The starting of fresh branches becomes almost a habit. One gets to know exactly what will be wanted, and the renting of a new house, its conversion, furnishing, opening and use become almost routine work. Nowadays large houses can be had almost in any number for the trouble of seeking them.

In England they are often called hostels, because from them the patients go out to daily work in the neighbourhood and return to sleep and spend their leisure time at the branch, the matron of which is responsible for finding the job and all the necessary supervision.

Necessarily, the patient has to make the journey each day alone. The work of the particular job has to be done, but there is always the matron to fall back on, to smooth things over if they get too difficult. Wages are handed to the matron, who gives pocket money at her discretion, and banks the rest for the future. Clothes can be bought, again at first under supervision. Later comes the job on licence. Even then it is advisable, in my opinion, that the defective should at first return to the branch during leisure time, partly because of the added safety this gives, partly because of the opportunity it affords for gossiping, swanking and keeping up such activities as Girl Guides. Later, they get their own bank-books, and return less and less often to the hostel. The institution of the future will have hostel branches or colonies in each of the large towns in the area it serves.

I believe that all defectives in any area who need more than supervision should come in the first instance to the central institution. That is the inflowing stream. I do not agree with defectives being sent direct to the guardianship of foster-parents. If a defective has failed at home, is it fair to the defective or to the guardian who will often know little more about the management of defectives than the parents, to send the case to much the same environment ? More important still, the defective has missed the skilled examination, training, treatment and the stabilizing effect of the institution.

The inflowing stream of defectives is studied, trained, treated by experts in the schools, the workshops and, if necessary, in the hospital. They receive the best available medical and technical treatment. Above all, every effort is made to stabilize character, to increase the power of fitting into a new environment.

No doubt many of those received will always remain in the central institution or one of its colonies. These are the lower grade nursing and custodial cases, most of those with bad habits, most of the epileptics, and a proportion of the high grade unstable cases. That cannot be helped. But there should be, and if the scheme is to be of any use there must be, a steady outward stream to the smaller lakes which are to be fed from the parent institution. These smaller lakes are represented by the hostel branches, by foster parents, by the simpler type of institution and, to a small extent, by the defective's own home.

https://doi.org/10.1192/bjp.79.327.563 Published online by Cambridge University Press

The outward stream should carry—

Some to the hostel branches of the institution,

For day service,

For living-in service on license.

Some, perhaps not many, back to their own homes on licence,

To work outside their homes,

To work inside their homes,

And the medium grade cases to be cared for at home.

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.

Some to foster parents on license—

To work outside their new home,

To work in their new home,

And the medium grade cases to be cared for in their new home.

Some to the simpler type of institution.

This means either a branch or colony of the central institution, the special wards of a good workhouse, or one of the existing small homes.

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 residing 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 institution. This ensures absolute and immediate fluidity of movement inwards as well as outwards, between the centre and 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 the system of licence, because under it you can act immediately. The important thing is to be able to move a patient anywhere within the scheme, without difficulty and without the delay that is caused if you have to obtain a magistrate's order before a case can be moved.

There are other things the modern institution should do. Research I have already mentioned. Every large institution should be a training school, not only for the teachers and nurses on its own staff, but for anyone who wishes to take up the work, and especially for the staffs of the smaller homes who cannot otherwise obtain the necessary experience.

The staff should form a clinic for consulting and diagnostic purposes for the area around. Some think the medical superintendent should act as adviser to the local authority, but I doubt this. It is better that the superintendent of an institution should not be in any way responsible for the initiation of steps which will send patients to his institution. Some of the staff should be detailed to visit and keep in touch with all defectives on licence.

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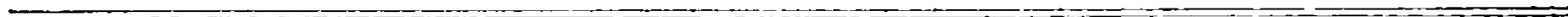
I have outlined what I believe should be the future policy of institutions for defectives. It is a recognition that the defective is in the majority of cases a normal person; it is a turning away from the alarmist doctrines of the immediate past back to the wider outlook of our forefathers—training and stabilizing the defective and leading him back to the world from which he came.

I am afraid I have wearied you all, but I hope you will forgive me, because of the great pleasure it has afforded me to air my pet theories.



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