drugs must be rare, and no such strains were found. This was supported by previous unpublished work by one of us (R. A. S.) in which an examination of 501 strains of *Staph. pyogenes* collected prior to 1950 failed also to show any strains resistant to aureomycin. Reports in the American literature suggest that resistant strains are becoming common among hospital patients in the United States. We have isolated strains resistant to aureomycin and strains resistant to chloramphenicol from patients in hospital. It is presumably only a matter of time before these organisms appear amongst the general population.

In view of the recent suggestion (Banks, 1952) that chloramphenicol is the drug of choice for treating penicillin-resistant staphylococcal infections, it is of some interest that the usual minimum inhibitory concentration of this drug for the organism in our series of strains was 32 times greater than that of aureomycin and 16 times that of terramycin.

Summary

Two hundred strains of *Staph. pyogenes* isolated from out-patients with staphylococcal infections of the skin and subcutaneous tissues have been tested for their sensitivity to penicillin, streptomycin, aureomycin, chloramphenicol, and terramycin.

Of the strains tested 16% were resistant to penicillin. No strains markedly resistant to the other antibiotics were found.

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THE ADOLESCENT FEEBLE-MINDED IN LAW AND PRACTICE

BY

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While there is general agreement that revision of the mental deficiency code is overdue, opinions differ on whether its future scope should be enlarged or be restricted among the subnormal. It is hoped that this account of a specialized practice will be conducive to a reorientation of views on the needs and prognoses of high-grade aments, encourage the allocation of suitable facilities for them, and indicate how both law and practice might better serve their interests and those of society.

Of the 1% of the population liable in certain circumstances to certification as mentally defective, about a fourth are so subnormal that they are a handicap, if not an intolerable burden, to the afflicted families. It is relevant, however, that the incidence of severe defect is equal throughout society and that its victims tend to assume, in both medical practice and popular belief, an importance out of all proportion to their social signifi-

cance. On the other hand, the implications of feeble-mindedness tend to be underrated, although high-grade aments constitute a formidable social problem. They comprise three-fourths of the potentially certifiable, and their incidence is greatest in the "submerged tenth"; but, unlike idiots and imbeciles, the majority become useful citizens if they are properly trained; neglected, they fail to realize their mental and social potentials, and many remain in the "social problem group" and contribute to its degradation.

Until the Mental Deficiency Act, 1913, became effective feeble-minded adults had no legal recognition and educational provision for feeble-minded children was merely permissive. The Mental Deficiency Act, however, imposed statutory duties on local authorities to "ascertain" the mentally defective "subjects to be dealt with" and to provide for their care and control. Unfortunately, however, the ascertainment of defectives remains quite inadequate, and even to-day only 50,000 beds (mostly taken by low-grade cases) are provided in England and Wales for aments of all classes and types.

The Manor Hospital

The Manor Hospital practice originated in the L.C.C.'s decision to develop its hospital services with regard for the very different needs of high-grade, as distinct from low-grade, aments and the suitability of its institutions for the concentration of facilities appropriate for one or other type of case. Thus in 1922 the Manor became a training colony for aments (mostly of high grade), but since the State assumed control in 1948 low-grade aments have been admitted in increasing numbers.

Among 1,470 cases on the books females rather outnumber males; 10% are children and 40% are incapable of socially useful improvement because of the severity of their disabilities. Training facilities include a school where young people between 10 and 20 years of age acquire, among other things, the rudiments of the three Rs; older inmates learn a variety of crafts and domestic arts in other departments; speech and occupational therapists cater for appropriate cases; Scout and Guide activities form part of the training regimen, and welfare officers place and supervise patients in wage-earning employment in the Epsom district. The general care of patients is vested in the medical and nursing staff, and psychologists function in an advisory capacity. Thus The Manor, although a hospital, has much in common with a large co-educational boarding school.

Some of the results achieved are shown in the table.

Unfavourable home circumstances are conspicuous in the case histories of high-grade patients under care at The Manor. Typical records include reference to some combination of parental cruelty, desertion, neglect, domestic discord, remarriage, sexual irregularities, and crime. "Social

	1951	1950	1949	1948	1947
On the books	1,473	1,471	1,451	1,437	1,390
On "daily service" ..	175	216	226	211	164
Advanced to licence ..	19	22	29	18	27
Failed "to make good" ..	38	69	49	52	26
On licence, both "local" and "distant"	218	216	223	236	270
Recommended discharges ..	29	29	20	35	30
Failed "to make good" ..	29	25	30	23	69

"Daily service" cases reside in hospital and go out to work in the Epsom district: they earn £2-£4 weekly, some a trifle less, and others much more. Those chosen for "local" licence reside with their employers or in lodgings, and are selected for this form of community trial either because they happen to be friendless or because their home circumstances are deemed unlikely to be propitious to their social habilitation; "distant" licence cases are placed in the care of parents, relatives, or employers further afield. Almost all licensed cases are fully self-supporting and many earn standard wages, which in some instances amount to £7-£8 weekly. "Teen-agers" rarely succeed unless their home conditions are exceptionally favourable, and, as a rule, patients on community trial need repeated tests, over a period of years, before they achieve tolerable social competence. Indeed, final discharge is rarely recommended until full adult status is attained.

parasitism," slum conditions, and large families figure prominently, and various mental disabilities are commonly attributed to members of the family group.

The Medico-legal Concept of Mental Defectiveness

Four classes of mental defectives were described in the Mental Deficiency Act, 1913, but mental defectiveness itself remained undefined until the Act of 1927 declared it to be "*a condition of arrested or incomplete development of mind existing before the age of 18 years, whether arising from inherent causes or induced by disease or injury.*" Unfortunately the new definition did nothing to end the traditional confusion of "intellect" with "mind"—that is, the part with the whole—and thus some still postulate a low I.Q. rating as a diagnostic prerequisite. The psychiatric validity of this procedure is not in question, but it is certainly inconsistent with the law as it stands. Moreover, it is indisputable that the feeble-minded, under present-day conditions, owe their social inadequacy more frequently to defects of character and temperament than to intellectual inferiority. The specific mention of aetiology in the definition of mental defectiveness created new difficulties because environmental factors (such as psychological traumata) cannot be subsumed logically under the headings "inherent causes," "disease," and "injury," although unfavourable conditions of nurture may certainly contribute to, and sometimes even cause, temporary or permanent arrest of mental development. Hence, on occasion it is necessary to assume that primary (inherent, endogenous) defect is a residual condition after the exclusion of cases attributable to "disease" and "injury" and so, with questionable logic, satisfy protocol.

Like its predecessor, the amending Act also classifies aments in terms of the degree and nature of their defectiveness. The value of this classification is debatable and, so far as moral defectives are concerned, unnecessary because they are *ipso facto* feeble-minded.

Clinical and Administrative Considerations

Bredmose (1946) holds that puberty is very protracted in the feeble-minded, and he advocates institutional care for them until their mental maturation is complete. He adds that many so dealt with succeed after discharge and that some advance, in terms of test-intelligence, into the "backward group". Clarke and Clarke (1952) report that some feeble-minded patients at this hospital have shown relatively large I.Q. increments at ages when mental growth is generally assumed to have ceased. Research is now in progress to elucidate the nature of this phenomenon and to determine the frequency of its occurrence.

Clinical observation suggests that the tardy blossoming of adolescent feeble-minded subjects as seen at this hospital is associated with their removal from unfavourable environmental conditions and the provision of training for them in new surroundings. Of course they cannot describe their childhood reactions to psychological traumata, but it seems probable that, in some instances, regressive or schizoid mechanisms contributed to their relatively poor test performances as well as to their social incompetence. Grossly subcultural nurture may have caused the retardation of others—it is significant that the I.Q.s of the few morons admitted from "average" homes have remained relatively unchanged during the years of adolescence.

Statistics indicate that maximum cognitive ability is achieved commonly about the fifteenth year—that is, about the age of puberty and school-leaving—but the flattening of the curve of normal mental growth which then occurs is merely a phenomenon of the mean, whereas the existence of variability about the upper level of the mean curve tends, as a rule, tacitly to be ignored; hence in some cases peak ability may not be attained until comparatively late in adolescence. Thus a variety of factors seem to be involved in the late maturation of many feeble-minded adolescents, and the fact that their test scores are often misleading cannot be attributed to any single causal agency. Nevertheless,

appropriate tests, applied in favourable test situations to subjects who have been able to acquire relevant informational experience, provide assessments of intellectual capacity and emotional attitudes remarkable for their accuracy and long-enduring validity.

The adolescence of the certified feeble-minded tends to be stormy, largely because the pace of physical growth is more rapid than that of mental maturation; moreover, unstable patients only too often find allies in subcultural parents against the sanctions of hospital care. Few aments from the social problem group are practised in self discipline and many are prone to relieve pent-up rage and frustration by short-circuit reactions.

Parole and tolerance of the friendly association of the sexes are elements of the training regimen, but the one occasionally leads to the abuse of the other; thus clandestine affairs occur and culminate sometimes in absconding, pregnancy, and, not infrequently, marriage. Both partners may be under care, but, more often, a female on licence and a non-certified but mentally or socially underprivileged male become intimate. The children from such alliances are unfortunate in both genetic endowment and prospects of nurture, and successive generations tend to be involved in the vicious circle of familial defect. The exposure of subnormals to temptation while denying them recourse to sterilization is one of the anomalies of mental deficiency practice; the mass sterilization of defectives would be both barbarous and futile, but opportune sterilization would undoubtedly assist many to survive socially and enhance the prospects of some under care to secure licence and discharge.

Male aments are the more prone to sexual crime—homosexuality, exhibitionism, and indecent assaults on children being the most common offences. For non-psychotic and non-epileptic adult offenders the social prognosis is so bad that segregation seems to be the only effective deterrent, but it is possible that the implantation of oestrogens might curb the libido of some sufficiently to justify the grant of short terms of licence.

Discussion

The Report of the Ministry of Health for 1951 states that no more than 50,000 beds are available in mental deficiency institutions, and the Report of the Ministry of Education for 1951 admits that, despite the ascertainment of the educationally subnormal (E.S.N.) being woefully incomplete, 28,000 E.S.N. children are competitors for 15,000 E.S.N. school places. With such inadequate provision for the subnormal the desirability of ensuring the most advantageous use of existing facilities is manifest; this cannot be achieved unless the ascertainment of subnormals is thorough and all candidates for residential care are investigated with due regard for their potentialities and needs, the circumstances of their nurture, and the best interests of the community. Obviously, life-long hospital care may be mandatory for many idiots and imbeciles, but it is relevant that for every low-grade ament admitted two, three, or more morons are deprived of the five or ten years of training upon which their successful social habilitation may depend.

Protocol caters for E.S.N. and feeble-minded children separately, but, in effect, applies standards of social competence (rather than of ability to learn the rudiments of the three Rs) in differentiating between them; thus ill-nurtured children who present evidence of subnormality are at a grave disadvantage when they compete for the inadequate E.S.N. facilities available. Moreover, if mentally underprivileged children are compelled by force of circumstance to remain exposed to adverse environmental conditions both "ineducability" and antisocial behaviour are not unlikely sequels. Paradoxically, however, really outrageous conduct may determine official action under mental deficiency law and secure the removal of subnormal victims of circumstance to an institution which happens to be suitably equipped, and thus lost ground may be made up tardily.

Of course institutional care is not a panacea for mental subnormality: the most admirable synthetic substitutes for

family life are not, as a rule, more favourable to the mental growth of young children than inferior, or sometimes even degraded, conditions of nurture; but the worse the home and the older the child the less cogent this generalization. Hence, when capacity for abstract thought appears at the mental age of about 7 years the interests of subnormal children and society need evaluation with regard to the probable effects of further exposure to bad upbringing.

Unfortunately the current demand for greater allocation of beds for low-grade defectives has led to the presence of an increasing proportion of hopeless aments among those with good prognoses. The resultant agglomeration of classes and types offends the sensibilities of even the least percipient newcomers to institutional practice; but many tend in time to grow indifferent to its social and psychological implications. Moreover, herding high- and low-grade cases in the same institution and under the same protocol intensifies antagonism to the mental deficiency code. Obviously, the mildly subnormal should not associate with the grossly afflicted and grotesque. Impressionable adolescents resent keenly their implicit identification with idiots and imbeciles, and parents protest, often with impeccable logic, that their children differ manifestly from low-grade cases and are indeed no more "mental" than they are themselves.

The sanctions of hospital care, including the (seemingly) arbitrary detention of potential wage-earners for indefinite periods and the application to subnormals of standards largely disregarded by their subcultural associates, contribute to the unpopularity of mental deficiency practice. Indeed, it is only when criminal charges may be preferred, or grave domestic crises occur, that certification and removal to institutional care are accepted with a tolerable, if ephemeral, show of resignation.

Although about 30% of the feeble-minded in hospital have been admitted direct from the courts, or indirectly via various corrective establishments, magistrates are, on the whole, singularly reluctant to deal with subnormal offenders as such. Lewis (1948) remarked that magistrates and juries tend to have their own criteria of mental defect and rarely recognize an adult as defective if his mental age exceeds 9 years; hence the paradox of indications of a high incidence of subnormality among prisoners and the insignificant proportion of them dealt with accordingly.

Conclusions

Problems presented by the subnormal in times of national emergency—the post-war crime wave, predictions of a declining national intelligence, and reports of "sensational" cases—have all focused attention on the social implications of high-grade defect. At the same time social attitudes have become more tolerant, full employment is (almost) a fact, the Disabled Persons' Register is open to the subnormal, and, in general, their material prospects have improved vastly. Despite, however, the advent of the Welfare State, the numerous feeble-minded progeny of the social problem group still need training and control in their own interest and that of others; but, while the parents of low-grade aments (being themselves "normal" people) press for school and hospital facilities, the subnormal and subcultural parents of the feeble-minded rarely do so. Thus lack of suitable training facilities, misinterpretation of the law, underestimation of the needs and potentialities of the juvenile and adolescent feeble-minded, inexcusable reluctance to face problems implicit in the exposure of the mentally underprivileged to adverse conditions, and failure to break the vicious circle of cause and effect in which they are involved—all these things, together with policies of *laissez-faire* in face of the overpublicized antagonism of uninformed opinion, have conspired against the best interests of the feeble-minded and those of society itself.

The importance of "nurture" rather than "nature" has been emphasized in this paper, because among the subcultural nurture is so often decisive in determining the existence of high-grade defect, social incompetence, and the need for official action. Hence for purposes of diagnosis

and prognosis it is futile to consider the moron apart from his environment, past, present, and future. In brief, the chief function of mental deficiency practice (apart from the humane custodial care of low-grade cases) is to rescue impressionable young morons from adverse environmental conditions and to control their behaviour while they are being trained to realize their mental and social potentialities. Thus, when their characters have stabilized and they have achieved tolerable social competence at the close of their protracted psychological adolescence, it may prove possible to return them, not to environmental situations which proved disastrous for them, but to social conditions in the community likely to afford them fair prospects of fending for themselves and remaining useful citizens.

Recommendations

It is hoped that separate legislative provision will be made for high-grade aments—that is, low-grade normals—including certain psychopaths who are certifiable as feeble-minded, and that the application of the existing Acts will be restricted to low-grade aments without prospects of socially useful improvement. These measures would entail: (a) the reservation of some existing institutions already equipped with the requisite training and educational facilities; (b) priority of admission for (i) the adolescent feeble-minded who are over school-leaving age and are "subject to be dealt with" as prescribed in the existing Acts, and for (ii) those of the juvenile feeble-minded who are excluded from school or for whom provision under the educational code exists in theory rather than actuality; (c) the transfer of failures to "simpler" institutions so that special facilities might be used most economically; and (d) the effective segregation of the vicious and depraved.

The question of cost is particularly relevant in times of financial stringency, and its answer is indicated by the fact that The Manor weekly capitation rate for the year 1951 was less than 65s. and was but a small fraction of reported equivalent rates for remand homes, approved schools, and H.M. prisons.

In any event, and certainly if high- and low-grade defectives are to remain subject to the same protocol, the following changes are thought to be necessary: (1) the exclusion of references to aetiology from the definition of mental defectiveness; (2) an unequivocal statement that the function of hospital care is to relieve, if it cannot remove, the social incompetence of the feeble-minded through the media of appropriate training and education; (3) the removal of the category of "moral defectives"; and (4) amendment of the definition of imbeciles to indicate that such persons are deemed to be permanently incapable of learning to lead an independent existence in the community.

Separate care and training for high- and low-grade cases are regarded as essential, and, in the sphere of administration, the case for the unification of responsibility for the ascertainment, care, training, and control of mental defectives is regarded as as cogent to-day as when it was recommended by the Mental Deficiency Committee (1929).

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