REFRESHER COURSE FOR GENERAL PRACTITIONERS**THE BACKWARD CHILD—II. SCHOOL AGE AND ADOLESCENCE**

BY

BRIAN H. KIRMAN, M.D., D.P.M.*Consulting Psychiatrist, the Fountain Hospital, London***Reasons for Certification at a Later Age**

The period after the age of 5, when the question of educability is decided, is critical for the ascertainment of mental defect. Adolescence is another critical period, when a group of children not previously certified are brought under the Mental Deficiency Act. Part of this group is made up of children who up to the age of 16 have been attending a school for the educationally sub-normal. In any such school, if residential, there is a large number of pupils who are illegitimate or for other reasons have no home. It is common practice for such children on leaving school to be sent to a mental deficiency institution. To obviate the need for this and to give these children the opportunity of finding useful occupation a hostel system similar to that until recently provided in agriculture by the National Association for Mental Health has been advocated.

Difficulties may also arise with those children already ascertained as deficient and excluded from school but not admitted to an institution. A common difficulty is occasioned by the death or illness of the mother. A parent who accepts full responsibility for the care of a deficient child has an additional burden and is perhaps more liable to ill-health. This has been recognized, and patients may now be admitted to mental deficiency hospitals for a maximum period of two months without the usual legal formalities. This procedure, if it is not abused by those seeking permanent admission for their children, should tide over any difficult crisis. A recommendation from the family doctor, setting out the details of the case and explaining the necessity for temporary admission, should be the normal basis for acceptance.

Legal Considerations

At all ages certification is the province of medical officers specially approved for the purpose by the local authority or by the Minister of Health. In this respect the procedure differs from that under the Lunacy Act. There is no obligation for the medical officers of the local authority to consult the family doctor, though it is clearly desirable that they should do so. The local authority medical officer acts in this matter rather by virtue of his experience as a school medical officer than on the basis of any special knowledge of psychiatry or psychology, though he will have had special training in the diagnosis of mental defect. A few local authorities arrange for psychiatrists to carry out this work. Usually two medical certificates are placed before a magistrate, who makes an order, although Section 3 of the Mental Deficiency Act provides for a procedure whereby admission of a patient under 21 to hospital is authorized on the basis of two medical certificates and a signed request from the parent or guardian, without a magistrate's order. This procedure, which is applicable only to idiots and imbeciles, is preferred by most parents as having something more of a voluntary nature. In an emergency a mental defective can be sent to an institution under the "Place of Safety" procedure (Section 15), pending arrangements for an order (Section 6) or for a Section 3 admission. Under this emergency arrangement, however, patients are sometimes sent to places which hardly justify the name

of place of safety—for example, a mental observation ward. When writing certificates doctors should constantly bear in mind the age of the patient. It is not uncommon to read about a child of 3 that "he is unable to manage his affairs."

Once made, authority for detention under the Mental Deficiency Acts holds good until it is due for renewal after an interval of one, one, and then five years, or until it is discharged. There is no escape clause similar to that under the Lunacy Act. No matter how well a patient may have adjusted to life in the outside world, he is always liable to apprehension if discovered before the renewal of his order is due. An exception is usually now made in the case of female patients who marry, it being assumed that the husband is able to provide the "care, supervision, and control" which a defective committed to an institution is certified to need. The Ministry has recently circularized hospitals concerned pointing out that high-handed action in such cases may serve to bring the Mental Deficiency Act into disrepute.

The superintendent of an institution for mental defectives has the authority to send the patient on leave for up to 14 days. For longer periods the patient may be licensed to the parents or to an employer, usually for three or six months, the licence being renewable. In such cases medical care for the patient becomes the responsibility of the family doctor. Hospital management committees have authority to make some financial allowance to patients and to others undertaking the care of a mental defective on licence. The allowance is similar to that which would be provided by the National Assistance Board.

Incidental Illnesses

Incidental illnesses in mental defectives do not present any greater problem than those occurring in children of the same mental age. Low-grade patients are less obviously distressed by pain than children of normal intelligence, so that they may be quite ill before the condition is noted. Refusal of food is often the chief symptom. Diseases, however, take a normal course in defectives and immunity is acquired in the ordinary way. Appendicitis and peptic ulcer are rarely associated with mental defect, though some cases may escape diagnosis. On the other hand, respiratory infections are unduly common, especially among mongols and gargoyles, whose expectation of life is reduced by the high incidence of bronchopneumonia. All young idiots and imbeciles are prone to inhale food particles when being fed, and, owing to weakness and inability to sit up, cannot respond with an adequate cough reflex. The position in mongolism may be further complicated by congenital abnormality of the heart, which occurs in 10% of all cases of this condition. It was formerly stated that mongols were peculiarly prone to tuberculosis, and that most of them died of this condition. This does not seem to be the case now, possibly owing to improved nutrition and reduced exposure to infection. The Mantoux reaction in mongols is converted to positive in the ordinary way after B.C.G. and vole bacilli inoculation, which seem to afford them the same degree of protection as the rest of the population.

Gross defectives are naturally incapable of following instructions about such matters as the taking of tablets. The feeble-minded and higher-grade cases may, however, be little different from the general population in this respect, though illiteracy may complicate the issue. In

case of doubt it is advisable to repeat all instructions and entrust all drugs such as phenobarbitone to a responsible person other than the patient.

Epilepsy in mental defectives is more commonly associated with the severer forms of mental defects, as might be expected, since both are due to an abnormality of the brain. There is little to be gained in gross idiocy by the use of anticonvulsants. In high-grade patients, however, it is important if possible to keep the epilepsy under control, since this may be the deciding factor in questions of educability and employability. Due care should, however, be exercised not to *increase* the degree of mental dullness by excessive dosing with phenobarbitone or other anticonvulsant. In using hydantoinate attention should be paid to the gums. The risk of confusional states arising from protracted treatment with bromides is now well recognized.

Employment

Certified mental defectives have limited civil rights and have some measure of special legal protection. Contracts into which they enter may be held invalid. They are not liable for military service. In fact, however, most high-grade defectives can be placed in gainful occupation. In general, there is undue caution in placing certified defectives, especially those in institutions, in outside work. It remains true that in times of considerable unemployment they are difficult to place. Also certain safeguards are necessary. Unless there is some supervision a defective may be employed for little or no wages for very long hours with no leisure time. Unless very much handicapped such a person should receive the full rate for the job. A suitable occupation and a sympathetic employer are also essential. The traditional occupation for boys and girls of limited intelligence are farm labouring and domestic service. To-day many factories can offer work which makes far less demand on the intellect than either of the above occupations. Many routine jobs of packing and assembling can be learned by high-grade imbeciles. A difficulty may arise in some cases because of the tempo of the work. Many defectives work more slowly than the average. It should be remembered, however, that many of those doing unskilled jobs, although not certified, have just as limited an intellect as those who have been labelled as defective. The latter may suffer, if they have been certified for long periods in an institution, from lack of experience of the world and lack of familiarity with money and day-to-day matters such as ration books and the various forms which are a part of modern life.

Neither epilepsy nor simple-mindedness need be a barrier to employment in many modern factories. Most modern machines are adequately protected so that they are literally "fool-proof." A defective who can be employed becomes at once much nearer to the normal. He gains in self-respect and feels himself like others. His character formation proceeds in a normal manner. It may seem at first sight that it is difficult to teach a job to defectives in view of the slowness with which they learn. If the job is such, however, that it can be broken down into a few simple components, and if it is taught patiently over a lengthy period, individuals of very low intelligence can master it. Effort spent in training in such cases is well worth while, since it may make the difference between an individual being a burden on the community for the whole of his life and being a useful member of society.

Delinquency and Defect

The problem of juvenile delinquency has some connexion with mental deficiency, but it would be quite wrong to equate the two. It is true that an undue proportion of those charged with minor offences appear dull. On the other hand, very dull people seldom have the wit to get into trouble on their own initiative. They are usually led into mischief by others, who often exploit them for their own ends. Being slow to appreciate the danger of detection, they are also very liable to be caught. Although there

is still a legal category of "moral defectives," this term is now little used: it is generally agreed that there is no special moral sense but that behaviour and character are modelled on those who surround the child from his early infancy. If the defective has a good environment he may well make a good citizen in spite of his limitations. Delinquent defectives are usually those with an unsatisfactory home and social background. The defect in the background is not always at once apparent. High-grade defectives are often very sensitive about their lack of success and may react with antisocial behaviour if they are not treated with due tact and consideration. However, it frequently happens that a defective is labelled delinquent because of the commission of some minor offence, often many years previously. It is seldom that people who are genuinely of really limited intellect commit serious crimes. There is much confusion of thought on this subject, largely because of failure to distinguish between insanity and mental deficiency.

Reproduction

Some supervision and protection of mental defectives is necessary, even after the age of 16, particularly in the case of girls. This protective attitude may be carried to excess and may interfere with the development of the character and independence of the protected individual, who has, through lack of worldly experience, become prone to be taken advantage of. Stress is often laid on the possibility that female defectives will produce large numbers of babies. In fact the number of babies born to mental defectives is small. The most fertile group in the community has a higher intelligence level than that which is usually associated with mental defect. Undue anxiety about this matter need not be felt on eugenic grounds, since most forms of mental defect are not due simply to hereditary factors and most defectives are born to normal parents.

A more serious objection to defectives having babies is that they may not be good mothers. Some supervision in this connexion is therefore desirable. If this is carried to excess, on the other hand, it may defeat its own object, since, if all open friendship with the opposite sex is forbidden, illicit relationships with undesirable results may be formed. A sense of proportion should be maintained in viewing the behaviour of defectives. It should be remembered that a high proportion of illegitimate births occur among the general population, and that if a feeble-minded girl becomes pregnant it does not follow that permanent detention in an institution is the necessary step. She may be capable of "learning her lesson" like other girls. She is more likely to do this if given the responsibility of caring for her baby, if she is at all fit to do so. Legally it is an offence knowingly to have sexual relations with a certified mental defective, irrespective of age and consent. Few charges are brought under this head because of the difficulty in proving that the man knew the girl was defective.

It is sometimes implied that the majority of prostitutes are mentally defective. This is far from being the case. A true defective seldom embarks on a life of prostitution on her own account, though in this respect also she may be exploited by others. It should not be assumed that defectives are abnormally interested in sexual matters; if anything, the reverse is the case. Certainly in low-grade cases there is often little sexual development. Mongols are often almost asexual and apparently have no capacity for reproduction in the majority of cases. When male defectives are guilty of sexual offences these usually take the form of exposure and masturbation in public.

There are many advocates of sterilization for mental defectives, and this practice is legal in some American States and elsewhere. A study of results observed is not impressive. It is also difficult to reconcile compulsory sterilization with prevailing ethical concepts in British medicine. As has been suggested, sensible supervision and advice are enough in most cases to guard against the birth of babies to certified defectives, who in any event form only a fraction of the intellectually dull.

Advice to Parents on Further Children

Apart from advice about the patient, parents of a defective child will often seek advice on their own behalf. They are usually very interested in the aetiology of the defect and its possible transmission. With younger parents, or those with only one child, the problem of whether to "risk another one" arises. In most cases parents are well advised to take this risk, though the facts, so far as possible, should be presented to them and the decision left with them. The immediate reaction to the birth of an abnormal child is often to decide against a further one. If the affected child is the only one parents are liable to become morbidly interested in it to the detriment of both themselves and the child. The odds are heavily against the birth of more than one defective in a sibship unless it is one of the uncommon conditions definitely known to be hereditary—phenylketonuria, epiloia, etc. Most of these conditions are readily recognized. The characteristic butterfly-shaped rash at the sides of the nose betrays epiloia; the green colour in the urine on addition of a few drops of liquor ferri perchloridi characterizes phenylketonuria; the hairy features and distended belly are characteristic of gargoylism. A careful family history is of course essential, though evidence of unrelated neuropathies—for example, senile dementia, schizophrenia, cerebral arteriosclerosis—is not relevant, especially in distant members of the family. Before arriving at a decision in such a matter it is desirable to have the child examined by a paediatrician or expert in mental deficiency.

Occasionally it happens that there is more than one defective in a family, sometimes without it being possible to ascribe the condition to any particular syndrome. In these cases further children are inadvisable. Ordinary methods of birth control are usually adequate, but sterilization may be indicated. Rhesus blood group incompatibility raises a special problem. If one child has been so severely damaged as to be mentally defective the prognosis for a further affected child is poor. However, if the father is heterozygous there is an even chance that a subsequent baby will not be affected.

Parents may also seek advice about the possibility of the transmission of the defect through their normal children to their grandchildren. They can usually be reassured on this score, with emphasis on the environmental factor, but in conditions such as phenylketonuria and gargoylism the possibility cannot be overlooked.

Conclusion

Mental deficiency is still very much a blank space on the medical map. Much more information is needed about the natural history of children with limited ability. This information is not readily got from institutions where children grow up under abnormal conditions which may themselves cause what are thought to be the typical features of mental defect. The general practitioner can do much to fill this gap in our knowledge.

In general, mental defect should not be seen as something fixed, rigid, or conforming to set patterns. In this as in all other branches of medicine individuals must be studied as such. No matter how gross the defect each has his own individual peculiarities and traits. In spite of the absence of specific therapy for this group of conditions the outlook is by no means uniformly gloomy. The family doctor can by a sympathetic and understanding approach help to solve many of the problems arising from those of his patients with less ability than their fellows.

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A SCHEME FOR THE ORGANIZATION OF A MILK-ROOM IN A GENERAL HOSPITAL

BY

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With the rapid development of the country's paediatric service the traditional feeding of infants according to the fancy of the ward sister is being replaced by the prescribed feeding of the paediatrician. The latter has usually been trained in hospitals having expensive milk-formula rooms. The provision of such rooms in all hospitals and maternity homes is economically impracticable, and advice on the subject is asked by paediatricians with beds in many and diverse hospitals.

The advantage of the milk-room lies chiefly in the production of accurate, varied, and clean milk formulae. The disadvantage lies in the danger of rapid and widespread dispersal of infection among the babies of the hospital. Unless a system is almost foolproof the possible disadvantage outweighs the advantages of a central milk service.

FIG. 1.—Showing the general plan of a milk service. Note in particular that the materials from the ward do not go direct to the milk-room.

The system described below was introduced into a Sheffield hospital three years ago, when a milk-formula room was developed and when no extra equipment was available. The system (Fig. 1) has worked extremely well; regular bacterial checks have been satisfactory, and the milk service has entailed virtually no capital outlay on the part of the hospital. The essential points of the system are: (1) a sterilization barrier between the wards and the milk-room; (2) after preparation the feeds are capped and sterilized by steaming; and (3) the nurse feeding the baby does not handle the teat of the feed-bottle.