A SURVEY OF 100 CONSECUTIVE CHILDREN AWAITING ADMISSION TO A MENTAL DEFICIENCY HOSPITAL

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Owing to the acute shortage of beds in mental deficiency hospitals, the problems connected with long waiting-lists are becoming more serious. Parents may have to wait several years before they are offered a place for their child. The Fountain Hospital, of 600 beds, usually admits children under 5 years; in theory they should be transferred in early adolescence to other mental deficiency hospitals, but, owing to the limited provision for adult low-grade defectives, the number of transfers is small. A few children improve enough to be accepted for educationally subnormal schools or schools for the handicapped, etc. (Kirman, 1958; Craib and Woodward, 1958). Vacancies also occur when children go home on licence, die, or move to other branches of this hospital. The area covered by this survey included south-east London, south-west London, and Surrey, thus presenting the problems of both town and country.

The aim of the survey was to assess the social and psychological problems associated with young defectives awaiting admission. Statutory supervision is carried out by the local authority while the defective child remains at home, and the present practice is generally for the home to be visited by the hospital social worker when a vacancy is being considered. Out-patient appointments are made when the parents particularly request this.

Method

The Fountain Hospital is situated within the London area, and in 1948 the administration was taken over by the South-West Metropolitan Regional Hospital Board. Owing to the need for these children to be visited regularly and the demand for beds for young defective children, arrangements were made to admit children from the London administrative areas outside the jurisdiction of the regional board. Vacancies are allocated between the areas, and additional vacancies are credited to the individual regional hospital boards which arrange transfers to adult hospitals for patients becoming too old to remain in this hospital. Of those still awaiting a vacancy there are over three times as many from one area as from the others. In our visiting, therefore, it was not surprising that many of the most urgent cases were found in this one area.

The survey deals with 100 consecutive names on the hospital waiting-list. The period covered was from September, 1955, to May, 1957. A combined visit was paid to the home by the social worker and psychologist, after making a written appointment. In the present inquiry this visit was made much earlier than usual. The ordinary hospital pre-admission form was completed by the social worker with the mother. This form is designed to obtain medico-social information about the child's early history together with his physical development, any previous hospital treatment, and the family circumstances. The precipitating factors which led the parents to ask for admission were noted and the psychologist tested the child and discussed his early development and present abilities with the mother.

Material

At the time of writing 50 of the 100 children no longer required a vacancy at this hospital: 12 had died, 21 had

been admitted to other M.D. hospitals, 8 were no longer considered mentally deficient, 5 were able to stay at home, and in 4 cases the parents had moved from the catchment area. Of the remaining 50, 39 were still waiting admission and 11 had been admitted or offered a vacancy.

In 64 cases the reasons the child needed hospital care were discussed with the parent or guardian. These 64 cases included the 50 still on the waiting-list or admitted, plus 14 who later had their names withdrawn for reasons such as death or admission to other hospitals. In each case the main precipitating factor was assessed as well as any additional factors; these are given in Table I. Some of these factors need further amplification.

Factors Precipitating Request for Admission

	Main	Additional
(1) Physical care of the defective had become too much for the mother	18	7
(2) Parents wanted the defective's name retained on the waiting-list for the future	13	0
(3) Defective in the care of the children's officer	7	0
(4) Parents concern over the adverse effect on their other children	6	13
(5) Hospital care considered necessary for defective or the child removed at birth	5	10
(6) Parents abroad	4	0
(7) Family illness or birth of a further child	3	6
(8) Defective's behaviour was disturbed or destructive	3	1
(9) Marital disharmony	3	1
(10) Housing difficulties	1	8
(11) Parents considered that the defective needed hospital training	1	0

(1) In most cases it appears that it is the physical strain of looking after the child that precipitates a request for admission. Some of these children are heavy and helpless, and the strain on the mother becomes too much. When temporary care can be arranged (up to a maximum of eight weeks), this sometimes enables the mother to keep the child at home. For many mothers in this group there is the added emotional strain of having a severely handicapped child; the extent of this could not be assessed in a single interview.

(2) A number of parents realized that they would not always be able to care for the defective at home, and some felt the security of having the child's name retained on the waiting-list in case an emergency arose.

(3) Seven of the children have no home, are illegitimate, or have been abandoned. Whilst awaiting admission these children are placed in a nursery or foster home by a children's officer.

(4) For many normal children a defective sibling is an embarrassment and a tie, and the mothers cannot give them as much time and attention as they need. Although the main precipitating factor is rarely the welfare of other children, nearly a third of the parents were considering their needs when asking for admission.

(5) Some of the most tragic families are those where the parents, having been told soon after birth that the child is mentally deficient, are then strongly advised to apply for immediate hospital care. In three cases the child was separated from the parents when 2 weeks old and was then transferred to a private nursery while waiting for a hospital vacancy. The hydrocephalic child and the mongol child are particularly prone to such circumstances. The hydrocephalic child may need more medical and nursing care than can be given at home, but the baby mongol presents no nursing problem in normal circumstances. In the families in this group where the mongol baby has been separated at 2 weeks, serious emotional difficulties in the parents have arisen. Some parents who were unable to afford a private nursery have later expressed their thankfulness at having given their child a period of home care during his early life. Only a small proportion of parents felt it was "right" for their child to be away from them. From the point of view of the child's emotional needs, a hospital for mental defectives is no adequate substitute for the individual care given by a mother.

The remaining precipitating factors are self-explanatory ; it will be noted that housing difficulties hold a relatively low position, although they appear to be an important subsidiary factor.

Psychological Tests

This survey was planned so that the children could be tested by a psychologist before they were admitted to a mental deficiency hospital, enabling them to be seen in their homes with their mother present. This was found to be helpful, as the mother was often able to describe the young child's achievements very accurately. However, directly speech was used to any considerable degree in testing, mothers found it difficult not to encourage the child, rephrase the question, or give the answers. From the mother's point of view, she could discuss the child's abilities on a developmental type of test with interest and very little guilt, but directly the child was asked to do specific items or to name objects, several mothers made remarks such as, "I haven't been able to teach him that yet," or, "Should I have done that with him?" or a more defensive and aggressive reaction was given such as, "Well, he couldn't do that because he's never played with things like that before." This last was said referring to test material which is usually new to a child.

Some of the mothers of mongols and gross idiots were very pleased to have their child tested ; mothers of these children with rather obvious defects sometimes felt that insufficient time had been spent examining the child's abilities. Before this survey was carried out it was not appreciated how helpful a test can be to a mother in recognizing for herself the approximate level her child has reached and in realizing that, although his development is slow, it is progressing along the same lines as that of other children.

In spite of the advantages of testing in the home, it seems preferable that the parents should visit the hospital, bringing the child as an out-patient, and that testing should be carried out by a psychologist then, leaving the social worker to visit the home alone. With a small group of children who show disturbed behaviour, however, it might be very valuable to see them in their own homes, as their behaviour sometimes appears to change markedly on admission.

The testing was carried out to find the I.Q. scatter in 100 children awaiting admission and to investigate any who might later be considered educable. But, for the reasons already given, testing of the whole 100 was found to be impossible, so that the children described are the 50 remaining on the waiting-list or already admitted.

The children were tested with the Griffiths mental development scale and/or the Vineland social maturity scale, except for one mongol of 7 who was given a Terman - Merrill revision of the Stanford-Binet test, Form L. Where two tests were given the scores were averaged. This is of course not standard practice, but was suitable for the purpose of this survey. The results are given in the Chart.

I.Q. scatter of children awaiting admission to a mental deficiency hospital.

The average I.Q. of this group was 25, with a range from 2 to 84. All the children with I.Q.s over 50 were mongols. The average age of all the children on June 30, 1957, was 2.9, with a range from 3 months to 7 years. It was found that these children divided naturally into four groups—mongols, other imbeciles, idiots, and a group of children who showed severe behaviour disturb-

ances and were consequently very difficult to assess accurately. In the whole group there were over three times as many boys as girls, the numbers being 38 boys and 12 girls. The ratio between boys and girls in each group was two to one for mongols and imbeciles, four to one for idiots, and eight to one for disturbed children. With such small numbers the high ratio for disturbed children can only be suggestive ; the other ratios are similar to those usually found. The I.Q.s, I.Q. range, average ages, and age ranges of the various groups are given in Table II.

TABLE II.—I.Q. and Age of Four Groups of Children Awaiting Admission

Group	No.	I.Q.		Age in Years	
		Average	Range	Average	Range
Disturbed	9	31	17-49	4.25	2.42-5.67
Idiots	20	7	2-16	2.75	1-5.08
Imbeciles	9	30	25-40	2.83	1.75-4.5
Mongols	12	45	13-84	2.33	0.25-7
Total ..	50	25	2-84	2.92	0.25-7

Of the 50 children tested in this group 12 were mongols, 20 were low-grade idiots, and 9 were imbeciles. These groups showed no marked behaviour problems ; however, the nine remaining children showed severe emotional symptoms. The behaviour of these disturbed children might be due to brain damage, psychosis, emotional disturbance, or deafness, or any combination of these. They appeared to be physically fairly normal, although a little undersized. Their behaviour was characterized by restlessness, mannerisms, screaming attacks, perseveration, and avoidance of contact with people, although they sometimes made contact with their parents. The histories of these nine children were investigated, and in three cases there had been a disturbed background, early separation, or neglect, but in the other six there was no obvious explanation ; the child had been at home with apparently well-adjusted parents and had normal siblings. It was decided to assess the backgrounds of the remaining children. Each child was considered in alphabetical order and put into one of two groups : those who had been separated from their mother for over three months, who had been abandoned, or whose parents showed signs of neurosis were described as having an abnormal background, while those who had spent all their lives in a stable home were described as having a normal background. The results are given in Table III. It will be seen that the homes of the disturbed children are no less stable than the others.

TABLE III.—Number of Children Coming from Normal and Abnormal Homes in Each Group

Group	No.	Normal Home	Abnormal Home
Disturbed	9	6	3
Idiots	20	13	7
Imbeciles	9	4	5
Mongols	12	6	6
Total ..	50	29	21

Discussion

It is realized that this division into "normal" and "abnormal" is rather arbitrary, that there may be hidden factors which have been overlooked, and that in some cases the child's original deficiency may have caused the abandonment, long hospitalization, etc. ; however, nearly half the children in this group have had enough in their upbringing to justify disturbance, and the disturbed children's background does not appear to differ from the others. This was contrary to what was expected, and might be due to the smallness of the numbers, or the disturbed behaviour being caused by other than environmental factors. This does not detract from the possibility of individual children functioning on a defective level for no other reasons than emotional ones.

The high incidence of children with disturbed backgrounds is due to this group being selected because, for the various

reasons given above, their parents felt it best for them to come into hospital care. However, nearly all the parents seen wished strongly that they could have managed to keep their child at home.

The further study of differences between behaviour at home and behaviour in a new environment such as a hospital may prove of use in distinguishing the components of this probably mixed group who show disturbed behaviour.

The earlier home visit was found to be useful for several reasons. Firstly, to give the parents the opportunity of discussing their individual anxieties about the hospital with the hospital social worker. These anxieties are very varied, and include advice on allowance, delays in admission, emergency provisions, visiting arrangements, sick-notice procedure, availability of medical advice, legal implications, clothing, and provision of toys, as well as the child's future placement. In some cases the parents are not sure whether they want a vacancy, and wish to discuss this with the hospital social worker in order to clarify their ideas on hospital care.

Secondly, the visit was useful to correct any serious misunderstanding regarding the child and his hospital treatment. As patients naturally wish their child to be "cured" and some hope for curative treatment, it is necessary to explain to them that, although research is being carried out, as yet it is unwise to expect any cure. It is important to correct misconceptions such as that mongols usually die at 5 years of age and that the children are kept permanently in bed. Before visiting the hospital the parents may not realize the essential differences between this hospital and one for general medical treatment. With increasing awareness of mental deficiency in society, it is now rare for the parents to confuse mental illness with mental deficiency, but when this occurs it is important to clarify the position before the child is admitted.

Thirdly, at this home visit an out-patient appointment can be suggested, and this provides an opportunity for the parents to consult a specialist and see the hospital, and for the child to have a pre-admission assessment by a psychologist. This psychological test is useful as an early record and for research purposes. It also affords an opportunity for eliminating educable children from the waiting-list; it has been found that they are more likely to succeed if they go straight to school instead of having to adjust to an initial period of hospital care.

Lastly, an earlier visit is useful in making known the specialized services and experience of the hospital. These include arranging friendly contact between parents of waiting-list children and parents of those already admitted, and giving general advice on training and feeding when requested. Some of the parents felt that their normal home care for the child might be inadequate; one parent was very worried because, despite the fact that her child had a good set of teeth, she could not teach him to chew, not realizing that this was quite usual. Most of the parents were aware of the provision of temporary care, but wanted to know exact details from someone working in the hospital.

There was a discrepancy from area to area in the ways in which parents had been helped. Where statutory supervision is carried out by trained social workers the parents appeared to be more adequately informed of the implications of hospital care. Nevertheless there was still a need for a direct personal contact between the hospital and the parents. This would almost certainly lead to closer co-operation in future years.

In spite of the advantages of an earlier visit a difficulty is presented by the fact that out of the 100 consecutive cases 50 were withdrawn for various reasons. Nevertheless it is considered that the earlier visit would help the parents to adjust to the various problems relating to having a defective child. Likewise, the pre-admission testing by a psychologist would be found most valuable, not only in assessing the child's abilities but also in observing his behaviour in relation to his parents.

Summary

One hundred consecutive cases awaiting admission to a mental deficiency hospital for children were investigated. Joint home visits by a social worker and psychologist were paid to find the factors precipitating the request for admission, to test the child's intelligence, and to assess the usefulness of an earlier home visit by the social worker. In spite of the extra time involved, the value of an earlier visit was thought to be considerable. The children were found to divide into four categories, their I.Q.'s and age ranges are given, and a review was made of their home background. Out-patient visits to the hospital for examination and psychological testing are recommended, with home testing only in special circumstances.

REFERENCES

- Craib, M. F., and Woodward, Mary (1958). *J. ment. Sci.*, 104, 115.
Kirman, B. H. (1958). *Ibid.*, 104, 167.

ISRAEL MEDICAL ASSOCIATION FOURTH WORLD ASSEMBLY

[FROM A SPECIAL CORRESPONDENT]

The Israel Medical Association held its fourth world assembly at Tel Aviv from August 12 to 24, under the chairmanship of Dr. J. BICKELS. Great Britain was represented by Dr. E. E. LIEBER. The inaugural ceremony was attended by both the Prime Minister of Israel and the Minister of Health. Dr. S. WAND, Chairman of Council of the B.M.A., attended the last two days of the meeting, and was made an honorary member of the Assembly.

Professor Zondek's Address

Welcoming the overseas delegates, Professor HERMAN ZONDEK said that, though they might see in Israel problems and disease entities bearing the stamp of local climatic, nutritional, and social conditions, it would be absurd to speak of a national or specifically Jewish medicine. There was, however, an intimate connexion between the teaching of Judaism and the ethical aspects of medicine. The *Old Testament* message, Man is made in the image of God, imposed for the first time the moral obligation to respect the sanctity of life, a postulate that formed the ethical foundation of their profession. In the spirit of this tradition Jews had always shown a marked affinity to medicine, and for centuries this attitude had been instrumental in leading a disproportionately great number of Jews to the study of the natural sciences and to the medical profession.

Professor Zondek then turned to the scientific aspects of medicine. What had been their contribution to the philosophy underlying the profession of medicine? Not so long ago scientific thought had been largely dominated by the mechanistic doctrine of causality, reflected in such trends as rationalism, materialism, Darwinism, naturalism, and so on, until the human organism had been converted into a soulless machine. However, deeper insight into the workings of Nature had given a new direction to natural philosophical thought. In their lifetimes they had been privileged to witness the enormous strides made by the physical sciences, and not least by medicine; and yet they had not come a single step nearer to solving the essential riddle of life. Some examples from his own field of research would illustrate what he meant. "When I was a young assistant at the Charité in Berlin, nearly fifty years ago," said Professor Zondek, "the question cropped up whether the ganglia of the heart were responsible for the movement of the heart muscle or whether the latter possessed an inherent capacity for its activity as advocated by Ludwig and my teacher His. I still remember the crucial experiment which, at the time, roused much comment. A small piece of embryonic chicken