

62



111
948
THS

THE NON-MENTALLY DEFECTIVE PATIENT IN
A STATE INSTITUTION FOR MENTAL DEFECTIVES

by

BYRON HOSMER

JUNE

1960



3 1293 00572 4863

~~11-6-75~~ 150

THE NON-MENTALLY DEFECTIVE PATIENT
IN A STATE INSTITUTION FOR MENTAL DEFECTIVES

A study of factors contributing to commitment and an
examination of social work activities leading to discharge.

by

Byron Hosmer

A PROJECT REPORT

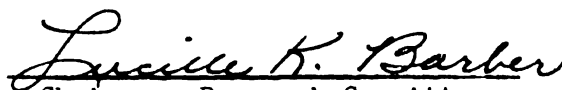
Submitted to the School of Social Work
Michigan State University
in Partial Fulfillment of the
Requirements for the Degree
of

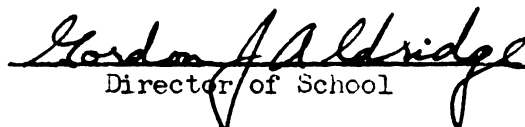
MASTER OF SOCIAL WORK

June

1960

Approved:


Chairman, Research Committee


Director of School

ACKNOWLEDGEMENTS

I wish to gratefully acknowledge the willingness with which the facilities of the Lapeer State Home and Training School were made accessible for the completion of this research. The leadership of the late Doctor A. T. Rehn, medical superintendent, in promoting the welfare of the mentally defective patient made possible the ready review of existing professional practice. He succeeded in establishing a stimulating climate of professional advancement and development that has been of great personal benefit to me.

I further wish to express my appreciation to my faculty research committee, Mrs. Lucille Barber and Mr. Arnold Gurin who contributed to the structure of the project design and guided the formulation of the report.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	ii
Chapter	
I. INTRODUCTION	1
II. THE LITERATURE AND CURRENT OPINION	10
III. METHODS AND PROCEDURES	18
IV. PRESENTATION OF DATA	23
V. SUMMARY AND IMPLICATIONS	47
APPENDIX	55
BIBLIOGRAPHY	57

CHAPTER I
INTRODUCTION

This paper concerns itself with that group of patients who have been duly adjudicated, committed and admitted to a State Home and Training School, but upon admission are found to be not mentally defective. Through personal knowledge of the institution and its workings, it is apparent to the writer that these non-defective patients are a source of some problems and are demanding an undue amount of professional staff time. There is the further complication of the state statute which states, "The medical superintendent shall discharge....a patient committed to an institution as insane, feeble-minded or epileptic and who in the opinion of the medical superintendent is not insane, feeble-minded nor epileptic at the time of admission to the institution."¹ Such discharges are not always feasible and frequently demand considerable effort to effect at all. As a result, time that should be spent with appropriately placed mental defectives is being spent with inappropriately placed non-mental defectives.

¹Michigan, Act 151, Public Acts (1923) as last amended by Act 235, Public Acts (1945), Section 25.

To study this problem, it was decided to take the admissions for one calendar year and to screen from them the patients who were initially diagnosed not mentally defective. The statistical division of the Department of Mental Health did this screening and from the admissions of 1956, thirty cases were identified as not mentally defective. They furnished information regarding name, number, sex, admission date, age on admission, urban or rural environment, record of community misconduct and intelligence quotient. With the study group thus identified, all additional information was obtained directly from the case records of the Lapeer State Home and Training School, by use of appropriate schedules.

The problem actually presents two facets: the identification of the group of non-defectives and their similar characteristics; the practice of the social service department in working with this group of patients. An elaboration of the former aspect of this problem will hopefully lead to a keener awareness that a substantial number of patients are inadequately or inappropriately diagnosed and are thus caused to reside in a setting that is not intended for their care and treatment. Accepting the fact then that such patients do exist in the present institution population and probably will continue to be admitted, it becomes necessary to learn in what manner their discharge can be best effected. Inasmuch as all discharge planning is the responsibility of the social service department, it is the intent of this study to learn what methods have been most successful in effecting the discharge of these patients.

The Lapeer State Home and Training School is "a hospital, home and training school for the humane, scientific, educational and economical treatment of feeble-minded persons."² It serves a specific geographic area of the state, consisting of the following counties: Alcona, Alpena, Antrim, Arenac, Bay, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Huron, Isabella, Iosco, Kalkaska, Leelanau, Livingston, Macomb, Manistee, Mecosta, Midland, Missaukee, Montmorency, Oakland, Ogemaw, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Saginaw, St. Clair, Sanilac, Shiawassee, Tuscola, Wayne, and Wexford. Appropriate patients for this institution are those who have been adjudicated feeble-minded by the probate court and who are consequently committed for care and treatment.

The Lapeer State Home and Training School is one of the largest institutions of its kind in the world. Its patient population varies from about 3500 to 4000. All types of mental defectives are cared for. There is no age limit and no lower limit on intelligence or ability. The upper limit of intelligence is, in practice, generally based on the results of psychological tests. Thus patients are generally considered defective and appropriate for care if they test below seventy on a standard scale of intelligence. The borderline defective range of from seventy to eighty is not generally considered to describe a mentally defective person and such a patient is not considered to be

²Ibid., Section 1.

appropriately placed in the Lapeer State Home and Training School.

Generally, all patients below the age of seven are assigned to the nursery. The program consists of routine nursing care for the youngest. As the children grow and develop, they are taught as much self-care as possible. Such training is carried on by the attendant personnel within the building.

Patients within the age group of five to eighteen and who possess intellectual capacity for education or training are enrolled in a school program. Two programs, generally comparable to type A and type B classes in the community, serve the educable child and the trainable child. The range of intelligence quotients is roughly from fifty to seventy for educables and thirty-five to fifty for trainables.

The patient in an educable program may progress to about the fifth or sixth grade level of academic skill. In his later years of schooling, emphasis is placed upon practical application of his knowledge so that he will be as well prepared as possible to take a productive place in society.

Following school, the educable patient is placed in a work training program. This consists of a regular job assignment on the grounds where he works under close supervision. This is not true vocational training. The primary focus is to develop good work habits rather than specific job skills. It is hoped that the patient will learn to accept responsibility for his job and to become amenable to supervision. When patients are successful in this area of training, they may become available for what is known as day work. This means

that they can go into the community and receive payment for a half day or a day's work. The opportunity for broader contacts, wider range of work skills and varying kinds of supervision is thus afforded them.

A recent addition to the work training program is that of full time day work. In this program, presently limited to male patients, the patient resides at the institution but works a full work week in one of the community's places of business. If a patient is successful on this program for one year, he is generally considered ready for a work placement in which he would also reside outside of the institution.

Trainable level patients (I.Q. thirty-five to fifty) will probably become institutional workers, following their school program. They will receive regular job assignments on the grounds and will usually work a regular work week. While some of these patients may do occasional day work, they are not generally considered to be candidates for work placement and discharge as independent citizens. Regular work is considered to give them a meaningful occupation of their time and to impart a sense of personal accomplishment.

A major portion of the institution's facilities is devoted to the care of the patient who is severely retarded. This group generally tests below thirty-five on an intelligence test. The general focus for this group of patients is to offer custodial care. Insofar as possible this group is taught self-care and organized recreational activities are provided for them.

At the time this study began, the social service department consisted of three units, two on the institution grounds and one in

downtown Detroit. One of the Lapeer units was the group responsible for all family care activities. The program of family care is one in which patients are placed in licensed boarding homes in various rural and small urban communities.³ The range of patients selected is quite wide, but the majority fall below the educable level. The exception to this is the occasional patient who is placed in a boarding home to attend a public school in the community. At the beginning of this study the family care unit consisted of a supervisor and four workers. It must be noted that this unit makes considerable use of practical nurses to make routine supervisional calls and transport patients for medical check-ups, et cetera. Home finding, annual evaluations for licensing and resolution of problems are handled by trained social workers.

When this study was begun, the second unit at Lapeer was responsible for all social services rendered to patients and their families, except those whose residence had been in Wayne County and

³For detailed information regarding this program see the following:

E. Beryl Bishop, "Family Care--The Institution," American Journal of Mental Deficiency, LVII, (October, 1954), p. 308.

E. Beryl Bishop, "Family Care: The Patients," American Journal of Mental Deficiency, LXI, (January, 1957), p. 583.

E. Beryl Bishop, and Ethelbert Thomas, Jr., "Family Care As A Source of Community Education," American Journal of Mental Deficiency, LXI, (July, 1956), p. 239.

Ethelbert Thomas, Jr., "Family Care," American Journal of Mental Deficiency, LX, (January, 1956), p. 615.

the southern edges of Oakland and Macomb Counties. This unit also was responsible for all placements outside the institution on what was technically known as convalescent status. The two placement programs consisted of home placement, in which a patient is placed with relatives, and work placement, in which a working patient is placed outside the institution on an employment basis. This unit was staffed by a supervisor and three workers, and employed both graduates and undergraduates.

The Wayne, southern Oakland and southern Macomb county area was the responsibility of the Lapeer Consultation Center, a social work office in downtown Detroit. This unit carried essentially the same responsibilities for their area as did the Lapeer unit for the remainder of the geographical area served by the institution. They traveled to Lapeer regularly for patient interviews and contacted families from the Detroit area both in the office and in the families' homes. They did not carry any family care cases. The office was staffed by a director and four workers and, like the Lapeer unit, utilized both graduates and undergraduates.

In the ensuing years covered by this study, certain administrative changes have taken place in the structure of the social service department. What was originally the family care unit assumed responsibility for the entire placement program. Thus family care, home placement and work placement for all cases outside the greater Wayne County area came under the jurisdiction of the unit which came to be known as the placement unit.

All patients on the grounds, including those from the greater Wayne County area, became the responsibility of the Lapeer unit, which became known as the inservice unit. All social services for resident patients and their families became the responsibility of the unit.

The Lapeer Consultation Center changed its name and function. It became known as the Detroit Consultation Center and began moving in the direction of becoming a social work field office for all Department of Mental Health hospitals and training schools. Their relationship with Lapeer patients then became one of supervising all placements in the greater Wayne County area. Again, this excluded family care patients.

Staff composition has changed somewhat in the years covered by this study. There have been additional personnel in all units, and a greater proportion of graduate workers than previously.

As stated previously, social service is responsible for all discharge planning. Patients who have been successful on either home or work placement are usually discharged by the medical superintendent acting upon the recommendation of the social worker. The staff, acting for the superintendent, may recommend that a resident patient be discharged. Such cases are then referred to the social service department for discharge planning. When plans that are not detrimental to the best interests of the patient and the community are worked out, the social worker will recommend discharge. The actual discharge is then made by the superintendent.

It is the purpose of this study, then, to seek out the identifying characteristics of this group of inappropriately placed patients and to determine why they came to be placed in an institution for mental defectives. The second phase of the study is to determine which of the original group were discharged and to endeavor to find the factors which led to discharge in some instances but not in others. The hypotheses that the social worker contributed to effective discharge will be tested.

CHAPTER II

THE LITERATURE AND CURRENT OPINION

The possibility that non-mentally defective patients are committed to and reside in institutions for the mentally defective has apparently received little thought, if the quantity of published material is to be considered as an indicator. However, a study was recently done and reported upon by Garfield and Affleck⁴ regarding the individuals in one such state institution who were discharged as not mentally defective. Their interest centered in the problem of incorrect diagnosis and factors that contribute to such problems in diagnosis. Their findings demonstrated an overemphasis upon the intelligence quotient and a lack of consideration of the emotional and environmental factors which might influence the subjects ability to score well on intelligence tests. They found a high percentage of cases who had been previously institutionalized. There was also a significant number of cases involving antisocial behavior, inadequate home situations or emotional disturbances. They indicate that such factors prompted

⁴Sol L. Garfield and D. C. Affleck, "A Study of Individuals Committed to a State Home for the Retarded Who Were Later Released as Not Mentally Defective," American Journal on Mental Deficiency, March, 1960, LXIV.

community attention and commitment to the state home followed because of a lack of more appropriate facility and/or inadequate diagnosis.

The area of diagnosis is a distinct problem area in the field of mental deficiency. The diagnosis must depend largely upon the definition and there does not seem to be unanimity of opinion here. In 1957, the American Association on Mental Deficiency published the following definition:

Mental retardation refers to that group of conditions which is characterized by: (1) inadequate social adjustment; (2) reduced learning capacity; (3) slow rate of maturation; present singly or in combination, due to a degree of intellectual functioning which is below the average range, and is usually present from birth or early age.

Mental retardation is a generic term incorporating all that has been meant in the past by such terms as mental deficiency, feeble-mindedness, idiocy, imbecility, and moronity, et cetera.⁵

This definition does not relate itself specifically to etiology. It lacks diagnostic quality and is a functional approach.

Jervis differs from this slightly when he states:

Mental deficiency is a condition of arrested or retarded mental development which occurs before adolescence and arises from genetic cause or is induced by disease or injury.⁶

While function is certainly a condition of the above definition, the reason for the impairment of function is here taken into consideration.

⁵Committee on Nomenclature, Statistical Manual, 4th ed. American Association on Mental Deficiency, 1957, p. 9.

⁶George A. Jervis, "The Mental Deficiencies," American Handbook of Psychiatry, ed. Silvano Arieti (New York, Basic Books, Inc., 1959), Volume II, p. 1289.

Such a differentiation would seem to exclude those persons who function at a retarded level, but do so because of environmental deprivation, emotional disturbance or psychosis. These would not be considered mentally defective, then.

Noyes⁷ crosses the lines in considering etiological factors, accepting causes acting prior to birth, causes acting at birth and causes acting after birth. In this latter group he includes retardation in intellectual development due to emotional factors without organic defect.

In 1959, the American Association on Mental Deficiency published a restatement of their definition:

Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in one or more of the following: (1) maturation, (2) learning, and (3) social adjustment.⁸

Here again, there is no differentiation made between mental retardation and mental deficiency. Little emphasis is placed on etiology.

The Group for Advancement of Psychiatry recently stated their definition as follows:

⁷Alfred Noyes, Modern Clinical Psychiatry (Philadelphia, W. B. Saunders Co., 1953), pp. 298-317.

⁸Rick Heber, "A Manual on Terminology and Classification in Mental Retardation" (A monograph supplement to the American Journal on Mental Deficiency, Sept., 1959), LXIV, p. 3.

Mental retardation is a chronic condition present from birth or early childhood and characterized by impaired intellectual functioning as measured by standardized tests. It manifests itself in impaired adaptation to the daily demands of the individual's own social environment. Commonly these patients show a slow rate of maturation, physical and/or psychological, together with impaired learning capacity.⁹

With regard to consideration of etiology in this definition, they state:

It would be preferable to classify mental retardation on the basis of etiology, but present knowledge makes this difficult. Therefore, classification is largely dependent on the use of symptomatology and the severity of the deficiency as the major criteria. Evaluation of mental retardation must include organic, psychological and social factors which are closely interwoven in this as in any other condition affecting the individual and his adaptation to the environment.

The diagnostic process is by no means complete with a mere determination of "mental retardation." An adequate diagnosis is concerned with the implications of the specific symptomatology, an understanding of etiology, a realistic prognosis and a comprehensive program of care, treatment and training. Diagnostic study and the subsequent treatment of the mentally retarded not only requires collaboration between the psychiatrist and pediatrician, but often calls for the help of many other medical specialists because of the frequent coexistence of multiple handicaps. The role of other professions such as education, nursing, psychology, and social work cannot be overemphasized.¹⁰

In some publications, a marked distinction is made between mental retardation and mental deficiency. The definitive use of these two terms can be most meaningful. World Health Organization utilizes such a distinction:

⁹Basic Considerations in Mental Retardation: A Preliminary Report. A Report Formulated by the Committee on Mental Retardation (New York: Group for the Advancement of Psychiatry, 1959), p. 7.

¹⁰Ibid., pp. 9-10.

To standardize the terminology, the term 'mental retardation' has been used in this report to refer only to those whose educational and social performance is markedly lower than would be expected from what is known of their intellectual abilities. When terms are needed to describe conditions in which the mental capacities themselves are diminished as a result of pathological causes, as opposed to environmental causes which may lead to mental retardation, 'mental defect' and 'mental defective' are used. (Those who suffer from mental defect may, of course, also be retarded.)¹¹

A similar position is taken by Masland, Sarason and Gladwin:

The diagnosis of mental deficiency clearly requires the presence of central nervous system pathology. Within this group, however, there is tremendous variation in degree and site of pathology, and, of great practical importance, in the degree to which normal intellectual and social development are possible. For purposes of this report we shall use the term mental deficiency or mental defect to refer to those individuals who have demonstrable central nervous system pathology of a kind and to a degree which probably rules out normal social and intellectual functioning. This, of course, involves in young children the prediction of status at maturity, which in some cases it is difficult to do. It should also be explicitly stated that although the diagnosis of mental deficiency implies irreversibility of the condition, it clearly does not rule out that in the future we will learn how to prevent entirely certain types of mental deficiency or bypass the drastic effects by early detection (e.g., galactosemia, phenylketonuria).

We feel it is important to differentiate between mental deficiency and mental retardation. Mentally retarded individuals...presumably do not have any central nervous system pathology...

From the standpoint of etiology, diagnostic clarity, prognosis, social implications, educational orientation, and research planning, it can only be a source of confusion if mentally defective and mentally retarded individuals are not differentiated from each other.¹²

¹¹The World Health Organization, The Mentally Subnormal Child, (The World Health Organization Technical Report Series, 1954), LXXV.

¹²Richard Masland, Seymour Sarason and Thomas Gladwin, Mental Subnormality, (New York, Basic Books, Inc., 1958), pp. 151-153.

Clarity of definition gives focus to all services for the prospective client. It first defines who is to be the appropriate patient and then dictates what type of program is to be offered the patient. Two patients may function at the same apparent level, but one may be mentally defective and the other mentally retarded, using these terms as defined above. The defective person functions as he does because of intellectual impairment and organically reduced capacity. The retarded person may function at a lower level because of emotional disturbance and/or environmental deprivation. To treat these two patients alike is to ignore the factors which caused the retardation in the second case. To allow this patient to utilize his full capacity, there must be attention given to relief of his emotional disturbance or improvement of his environment. Failure to make a diagnostic distinction between deficiency and retardation clouds the treatment plan and reduces the possibility of hopeful prognosis in cases of retardation.

To move away from inaccurate diagnosis and categorization of such patients and to insure that all deviant children receive the full benefit of available services, the Group for Advancement of Psychiatry made the following statement:

It is our conviction that there is need to so re-structure our psychiatric services that all therapeutic skills beneficial to children will be made available to the psychiatrically deviant child regardless of the specific category into which he may have been classified. Such a concept calls for the development of Psychiatric Centers for Children with diversified programs including in-patient, day hospital, and out-patient services.

The Psychiatric Center for Children's first responsibility would be that of comprehensive differential diagnosis followed by the development of a treatment plan based on the concept that the patient is first a child and only secondarily afflicted with an abnormality. This approach would eliminate overemphasis on diagnostic terms which in the past have determined administrative decisions concerning institutionalization or other disposition. At the present time, contacts between the family and state institutions for the retarded are directed toward the family's predetermined desire to "place the child."

A Psychiatric Center for Children would instead first offer diagnosis and then the development of an appropriate plan for constructive treatment, training and care as individually indicated. The center should draw on other community resources in its planning and should in turn be an integral part of community services for children.

...aggressive antisocial children who do not present primary symptoms of mental retardation, neurosis or psychosis should not be admitted to a Psychiatric Center for Children or present-day hospitals for retarded, neurotic or psychotic children. Wherever these children are cared for, there should be psychiatric services available for consultation work and individual therapy.¹³

It is obvious then that distinction must be made between the defective and the retarded. Cutts¹⁴ writes on the differentiation between pseudo-mental defectives with emotional disorders and mental defectives with emotional disturbances. He suggests that complete clinical evaluation is necessary for accurate diagnosis. He would include observation of behavior, objective test results, drawing tests, projective personality tests and case history material.

There are those in practice today who would accept in the state

¹³Group for the Advancement of Psychiatry, Basic Considerations in Mental Retardation: A Preliminary Report, A Report Formulated by the Committee on Mental Retardation (New York: Group for the Advancement of Psychiatry, 1959), pp. 16-17.

¹⁴R. C. Cutts, "Differentiation between Pseudo-Mental Defectives with Emotional Disorders and Mental Defectives with Emotional Disturbances," (American Journal on Mental Deficiency, 1957), LXI, pp. 761-772.

homes and training schools all patients who function as mental defectives. This would include patients with severe emotional disturbances, autistic children, childhood schizophrenics, and children from deprived environment. However, it would seem only reasonable that the treatment indicated should be based on accurate diagnosis. It would not appear that the treatment of the true defective would be identical to the treatment of a patient who functioned at a retarded level because of one of the above-noted reasons. If, then, the state institutions were to accept this type of child as an appropriate patient, it would be necessary to adopt a psychiatrically oriented treatment program for their care. Such programs do not now exist in Michigan and present staff ratios preclude their immediate adoption.

Inappropriate patients will probably continue to be referred to state homes and training schools. The professional workers in the field are not in agreement as to what mental deficiency (or mental retardation, or feeble-mindedness) really is. The law that created the state institutions does not define the appropriate population nor has the Department of Mental Health clarified the issue. The Lapeer State Home and Training School, by their lack of written policy and their varying recommendations, have not demonstrated clarity with regard to who their appropriate patient is, either.

Until some clarity is forthcoming in the field itself, agencies outside the field must be expected to continue to occasionally refer an inappropriate patient.

CHAPTER III

METHODS AND PROCEDURES EMPLOYED

When the general area of this study was defined, it was decided to take one group of non-defective patients and follow their progress over a period of time. It was felt that such a study would give a more dynamic view of the problem than to perhaps take the entire non-defective population and study them in any given moment of time. The question then was to find suitable criteria for choosing the population to study. It was felt that the group should not be taken from admissions of many years previous, because of the recent improvements in diagnostic and classification skills. Also, services available to patients should approximate what is presently existent.

On the other hand, it would be equally undesirable to pick a group of so recent admission that there would be no time elapsed in which to discern movement. It was then tentatively decided to see if the admissions for one calendar year would provide a sufficient number for study. The year chosen was 1956.

In April, 1958, assistance was obtained from the Statistical Division of the Department of Mental Health. From the resident population of the institution at the end of the year, all patients diagnosed not mentally defective were screened by means of an IBM machine. To

this list was added all patients discharged during the year who were diagnosed not mentally defective. It was necessary also to screen all patients on placement in 1956 who shared this diagnosis. These lists were then compiled and the following information printed by the machine: number, name, sex, environment, history of community misconduct, date of admission, intelligence quotient, and diagnosis. This list was then reviewed and those patients who were shown as being admitted during the calendar year 1956 were chosen for the study. This was a group of thirty.

All additional information was then obtained directly from the patients' case records at the institution. A schedule was prepared to classify pertinent information regarding each patient.¹⁵ The purpose was to gain as much identifying information about each patient as possible.

It was felt that this group of patients would present many common identifying characteristics and would have had many similar life experiences. It might have been predicted that the group would be primarily composed of adolescent and young adult males who came from an urban environment. It was anticipated that they would have been known to various social agencies, probably have had contact with a juvenile court and may have been in residence in other institutional settings. Prediction would be that intelligence testing prior to admission to Lapeer would range from sixty to eighty or from the defective range

¹⁵See Appendix A.

through the borderline defective range and that not all patients would have received such tests. It was expected that all psychological tests at Lapeer would range from seventy through one hundred or from the borderline defective range through the normal range.¹⁶ It could also be anticipated that a victim of cerebral palsy might be identified in this group of non-defectives because there is no appropriate state residential facility expressly for the care of this type of patient and they are not infrequently given residence at Lapeer. In summary, it was expected that the group of non-defective patients would be identified as those who had not made an adequate social adjustment and on the basis of this and an inability to score well on an intelligence test, had been committed as mentally defective.

This identifying material was readily available from the case record and was consistent from case to case. Some of the information was contained on the face sheet. However, it was also necessary to review the psychological test results, the social history and the copy of the court commitment papers. The running progress notes were also read and yielded information regarding staff recommendations, institutional program and adjustment, and date and type of discharge. Material from Schedule A, then, gave identifying information, pre-institutional maladjustment, institutional adjustment and time of discharge.

¹⁶ Nomenclature in common use at Lapeer for the ranges of intelligence in question are "defective, borderline defective, dull normal, and normal."

Another schedule was then prepared to classify data regarding social service activity with each patient.¹⁷ This material was taken solely from the running progress notes. The only exception to this was a check of the correspondence which revealed some social service activity which was pertinent to the study.

The patients' records at the Lapeer State Home and Training School are not kept for research purposes. They are kept only for care and treatment purposes and as such are lacking in some of the details that might be useful. The social history in most instances does not give extensive psycho-social history and frequently bears greater resemblance to a medical history. These histories are not compiled from a series of interviews with patient and/or family, but primary information is gained from a multi-page personal and family history form that the family is asked to complete. Additional information is obtained by sending letters of inquiry to doctors, hospitals, schools, and social agencies who have known the case. The primary purpose of the history material is to assist in diagnosis, classification, and planning.

The psychological testing program is intended to assist in diagnosis and in program planning for the patient.

The running progress notes are written by doctors and social workers, primarily; occasionally, notes from attendant personnel and nursing staff are included. The doctors include all hospitalizations in these notes, with diagnosis, treatment and response. Nursing and attendant personnel would enter notes usually only in cases of serious

¹⁷See Appendix B.

misbehavior in the building or on the grounds. Limitations of social service staff time and demands of large case loads preclude extensive recording by the caseworkers. It is generally acknowledged that only vital material is dictated; that is, such material that must be known to continue any given process with a patient. Also, recording would seem to vary somewhat between the three social service units. It appears to be the general impression that the placement unit and the Detroit Consultation Center do more regular recording than does the in-service unit.

This area of recording presents an unavoidable weakness in the reliability of any study involving the social service department. Through the writer's personal knowledge of the function of this department, it is apparent that only a portion of the number of interviews actually held are ever noted in the patients' folders. However, there is at present no better way to determine the activity of the social service department in the cases of this study than through the dictation found in the patients' folders.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Identifying Characteristics of the Non-Mentally Defective Patient

To begin the evaluation of the material gathered, the general identifying information will be examined. Material from Schedule A will be considered to determine the common characteristics of the study group and to see if the results are as predicted in Chapter III.

The general ratio of male-female patients within the institution is approximately one to one. However, the impression gained from the staff by the writer was that the non-mentally defective group would be predominantly male. This impression was borne out by the study, as the group consists of twenty-three males and seven females. The significance of this fact is not immediately clear but may be accounted for by the hypotheses that the male in community difficulty is more apt to be handled authoritatively than is the female.

The admission ages of this group show a much narrower range than is common in the institutional general population. Admissions may occur as early as one month or six weeks of age and a large number of children under school age are admitted. The range extends upward with no theoretical or actual limit. However, this group of patients' admission ages falls within a rather circumscribed range. This is shown

in Table 1. The actual range is from nine through twenty-five, the mean being approximately sixteen years, six months. Two-thirds of this group fall within the age range served by junior high and high schools. Here, then, is a group of adolescents who have a full-time community program established for them, but who apparently are unable to use it. It might also be concluded that this group was not identifiable as mentally retarded at an early age and even may have enjoyed some degree of success in the early school years. The six patients who were twenty and above are above the age anticipated for this group of patients, but even with their inclusion, the age range for the patients of this study is strikingly narrow.

Table 1

Age of Non-Mentally Defective Patients Upon Admission

<u>Age</u>	<u>Number of Patients</u>
Total	30
5, under 10	1
10, under 15	7
15, under 20	16
20, under 25	5
25, under 30	1

The study groups' environmental distribution of eighty percent urban and twenty percent rural is not dissimilar to the average population distribution and so is not a significant factor. Distribution

by county of commitment follows approximately the same distribution as the general population with nearly half coming from Wayne County, and the remainder coming in diminishing numbers from the more northerly counties.

It was anticipated that patients of this group were probably known to social agencies prior to commitment to Lapeer. This was predictable on the basis of the fact that they were probably not first recognized as being mentally defective but rather came to the attention of agencies because of inadequate social adjustment. It would be expected that social agencies offering protective services, or psychiatrically oriented diagnostic services would have been utilized. Also, antisocial behavior would precipitate contact with the juvenile court. These predictions were borne out in the study. Thirteen, or slightly less than half the cases, show a history of contact with social agencies. Nine of these had a history of public misconduct, ranging from truancy and juvenile delinquency through the commissions of misdemeanors and felonies. Of this group of nine, seven were males. All fell within the age range of fourteen through seventeen.

In an effort, no doubt, to ascertain the cause of the lack of adequate social adjustment, seven patients had been examined in various psychiatric facilities, such as Neuro-Psychiatric Institute and Child Guidance Clinics. One patient had been examined in three such facilities.

Inadequate environment is indicated in three cases, for the protective services offered by children's agencies were utilized.

As anticipated, two cerebral palsied children were identified in the group and they had been known to the Detroit Orthopedic Clinic. Their presence in Lapeer, even though they are not mentally defective, is generally accepted because of the lack of another specialized facility for their residential care.

It was felt that many of the non-defective patients received at Lapeer had been in residence in some other institutional setting prior to admission. This is borne out by the fact that two-thirds of the group in this study had histories of previous institutionalization. This includes four patients who were in boarding or foster home care.

The type of institution previously used gives strong indication of the problem that precipitated removal from the community. Public misconduct heads the list with six of the group having been in Boys' Vocational School just prior to commitment. Four of these boys, plus six others from the study group, had a record of being in a Juvenile Detention Home. The basic problem and the one most long standing in these cases would seem to be one of inadequate social adjustment.

Three facilities more nearly akin to Lapeer were utilized: Traverse City State Hospital, Caro State Hospital for Epileptics and Wayne County Training School. These institutions are designed to handle specific diagnostic entities and transfers of inappropriate patients to other mental health facilities is not uncommon. However, such transfers may not always be based on an accurate admission diagnosis, but may be precipitated after some length of time. The factors precipitating transfer may not be dissimilar to the communities

reasons for original commitment. That is, that the person in question does not fit into the existing programs, has received maximum benefit of the program, or has become troublesome and antisocial. Transfers and commitments upon such basis are not determined by diagnosis and prognosis, but by desire for removal of such a person. If diagnosis, prognosis and genuine desire to work for the best interests of the patient were motivating forces, it would be reasonable to assume that commitments and transfers would be made immediately upon diagnosis and that the receiving facility would be appropriate. In one case, a patient had been in Traverse City State Hospital for one year seven months before he was re-adjudicated and committed to Lapeer. Another was in Caro State Hospital for Epileptics for seven years eight months before coming to Lapeer. This patient's seizures had long since been controlled, but he was a distinct behavior problem. Two patients came to Lapeer from Wayne County Training School. One had been in residence for seven years and one for sixteen years six months. The Training School felt both of these patients to be too severely handicapped to gain further from their program. However, all of these patients were inappropriately placed at Lapeer, as they each were diagnosed not mentally defective. It would seem, then, that not only are some commitments from the community based on inadequate diagnosis and secondary motivations, but the same is true of some of the exchanges of patients with existing mental health facilities. It has become the general impression at Lapeer that the community and its agencies feel that if an appropriate facility does not exist, the patient or citizen should be accepted at Lapeer, regardless of whether

or not he is diagnosably mentally defective.

Indications are that four patients came from inadequate home situations in that they had been placed in boarding homes. This bespeaks physical deprivation at an early age and concomitant with this is the possibility of emotional neglect. Either of these factors may lead to arrested maturation and lack of full development of intellectual potential. One patient was placed in boarding care following three months evaluation and treatment in Neuro-Psychiatric Institute for such emotional disturbance and lack of development. Another patient had been in boarding care for a five-year period, and this represents the longest foster care for any of this group.

One other patient came to Lapeer after apparently exhausting the program of another state facility. This patient attended Michigan School for the Deaf over a four years five months period and was committed when they felt he could no longer benefit from their program because of his mental deficiency.

As noted in Chapter I, all patients coming to Lapeer are committed by the probate court in the county of residence. Such proceedings are begun by the filing of a petition. The petitioner may be a relative, guardian, peace officer, or any other interested person whom the judge of probate might deem suitable.¹⁸ In some instances, it is apparent that the petitioner acted upon the suggestion or recommendation of another. It was attempted to identify this second party also,

¹⁸Michigan, Act 151, Public Acts (1923) as last amended by Act 235, Public Acts (1945), Section 11.

whenever possible.

It might be assumed that in instances where the petitioner is not a relative, the subject to be committed has gotten beyond the jurisdiction of his family. This could indicate that the family has abdicated its rights through neglect, as might be expected in the cases where the patient has been placed in boarding care. It could also indicate that the subject of the petition has come under the jurisdiction of a community authority through antisocial acts of his own.

In tabulating the petitioners for this group, it appears that one-half of the group were committed on petitions filed by someone other than the family. It might be noted, too, that of the family petitioners, one acted on the recommendation of a child guidance clinic and one under pressure from the court. Thirteen admissions were at the instigation of police officers, social workers, or superintendents of other residential facilities. The remaining two cases are those whose record was not available. This is a substantial number, then, that apparently were no longer under the jurisdiction of their family, but had, through their behavior, come to the attention of community authorities.

The psychological test results for this group of patients are of great importance. Results of intelligence testing probably represent the most objectives and most frequently used means of determining mental defectiveness. Thus, anyone who fails to make an adequate social, educational or economic adjustment, may be tested at some point to determine if mental deficiency is the cause of his lack of adjustment.

If the subject is unable to score well on such a test, it is usually concluded that he is mentally defective and in need of institutionalization. On the basis of this, it might be predicted that the individuals in this study group had psychological evaluations prior to commitment and that they had scored within the defective range.

The patients' records were reviewed to determine what tests had been conducted prior to admission and within what range the patients scored. Of the twenty-eight records available, there is no indication of precommitment testing having been done in eight cases. In the remaining twenty cases, intelligence quotients ranged from fifty-eight to eighty-eight. The mean was sixty-eight. Nine of the patients tested above the defective range: eight within the borderline defective range and one in the dull normal range. It appears, then, that in eight cases no objective measurement was used to determine if the commitment to Lapeer was appropriate. In those cases where tests were used, the indications were that in nine cases commitment to Lapeer was contraindicated because the patient tested above the appropriate range. The reasoning behind the commitment of this latter group is difficult to determine with certainty. It may be that community agencies and the community at large do not know what type of patients Lapeer is equipped, by law and by program, to serve. It may also be that these patients needed to be removed from open society, needed some type of institutionalization and no more appropriate facility could be found.

Results of intelligence testing at Lapeer are very significant factors in classification and planning. Inasmuch as this entire group was originally classified as not mentally defective, it was predicted

that the entire group would test above the defective range. This was borne out by the study. The actual range of intelligence quotients attained at Lapeer was from seventy through ninety-four. Twelve patients tested in the borderline defective range, thirteen within the dull normal range and the remaining five within the normal range. The mean test score was slightly over eighty-five.

Table 2 presents pre-commitment test results and the results of tests at Lapeer soon after admission.

TABLE 2

INTELLIGENCE TESTS OF NON-MENTALLY DEFECTIVE PATIENTS

Patient	Pre-Commitment			Following Admission		
	Test	C A	I Q	Test	C A	I Q
1	WE-I	16-2	63	SB-L	16-7	87
2	WB-I	15-1	66	WB-I	15-10	79
3	SB-L	9-0	69	SB-L	23-9	78
	WB-I	18-1	70			
4	SB-L	10-2	66	WB-II	23-1	78
5	SB	4-8	64	SB-L	25-2	81
6	SB	5-3	75	WB-II	19-7	85
	SB	8-5	74			
	WB-I	15-10	64			
7	WB-I	14-6	70	SB-L	14-10	81
8	?	5-4	76	SB-L	12-11	88
9	* ?	?	?	?	?	79
10	SB-L	4-11	71	SB-L	14-0	93

*Record not available--Patient transferred to other institution.

Key: WB-I---Wechsler-Bellvue, form I.
 WE-II---Wechsler-Bellvue, form II.
 SB---Stanford-Binet.
 SB-L---Stanford-Binet, form L.
 WAIS---Wechsler Adult Intelligence Scale.
 WISC---Wechsler Intelligence Scale for Children.
 CA---Chronological Age.
 IQ---Intelligence Quotient.

<u>Patient</u>	<u>Pre-Commitment</u>			<u>Following Admission</u>		
	<u>Test</u>	<u>C A</u>	<u>I Q</u>	<u>Test</u>	<u>C A</u>	<u>I Q</u>
11	NONE			SB-L	14-1	73
				WISC	15-2	67
				WAIS	16-1	78
12	WISC	15-1	70	W-B-I	15-8	82
				WAIS	17-3	83
13	WB-1	15-0	65	SB-L	15-5	87
14	SB-L	11-11	58	WB-II	16-4	70
				WAIS	18-10	78
15	NONE			SB-L	15-8	93
16	Chicago	8-6	65	WISC	13-1	PQ 82
	Non-Verbal					
17	NONE			SB-L	23-8	80
				WAIS	25-9	81
18	?	?	70	WB-I	16-4	94
19	WB-I	16-5	68	WB-II	16-8	77
20	NONE			WB-II	16-11	88
21	NONE			SB-L	9-3	70
22	SB-L	12-8	71	WB-I	15-10	80**
				WISC	15-11	61***
23	SB-L	12-7	72	WISC	13-8	77
24	NONE			SB-L	23-8	94
25	* ?	?	?	?	?	85
26	WISC	11-10	70			
	SB-L	12-0	88	WISC	12-9	74
27	NONE			WB-1	22-2	72
28	NONE			WISC	15-5	93
29	WB-1	13-8	65	WISC	13-11	83
30	WISC	?	58	WB-1	17-0	75

*Record not available--Patient transferred to other institution.

**Estimated

***Invalid

This group's psychological tests represent five standard tests of intelligence: Stanford-Binet, Wechsler-Bellvue, forms one and two, Wechsler Intelligence Scale for Children and the Wechsler Adult Intelligence Scale. It is also noted that one deaf patient was tested prior to commitment on the Chicago Non-Verbal test. A careful analysis of the type of test given does not show it to be a significant factor in determining variations from one test to another. Of the seventeen cases where the type of test given before commitment is known, eight were some form of the Stanford-Binet and nine were some form of the Wechsler. Following admission, nine of these seventeen were tested on the same general type of test as was given prior to commitment. Five who had received some form of the Stanford-Binet before commitment, were evaluated at Lapeer on some form of the Wechsler. Three who had been tested on Wechsler scales received Stanford-Binets following admission. It does not appear, then, that variations between types of tests could account for the consistent upward variation in test results. Actually, in practice an intelligence quotient is probably usually accepted at face value, whether it comes from a Stanford-Binet or from a Wechsler test and regardless of what the correlation between these two tests might be.

Regardless of the types of tests administered, there is an appreciable increase in intelligence quotient scores from the pre-commitment tests to the tests done at Lapeer. The twenty patients who were tested prior to admission gained from four to twenty-four intelligence quotient points when tested at Lapeer. The mean gain was

14.95 points. Several theories might be advanced as to the reason for this increase, but no single theory would seem to apply to all the cases.

Guertin's¹⁹ hypothesis of slow mental maturation would seemingly explain some of the cases, but in others, the pre-commitment test and the new admission test were given very close together. The mean time lapse in months between the two tests was slightly over seventy months. However, eight of the cases were retested in less than one year and five of these in less than six months. The increase in these eight cases, then, could probably not be attributed to late mental maturation. However, five cases showed a time lapse of one to five years, two cases of more than five but less than ten, and two others of more than ten but less than fifteen. One patient showed a lapse of twenty years, six months between tests. In these ten cases, slow mental maturation might account for increase in intelligence quotient.

Grace Arthur spoke to this point when she stated:

...some adolescents pronounced incorrigible before their arrival at (the State school), responded promptly and continuously to healthy living conditions, courteous treatment, efficient teaching and a good recreational program. For the first time in their lives they found themselves liking school and cooperating in a constructive program. With better work habits, improved physical conditions and increased rate of learning, some of the Binet ratings began to increase and continued until they reached a level of ...(dull normal)... These individuals were not regarded as "cured," but as having made an adjustment that permitted a more nearly accurate measurement of their mental capacity.²⁰

¹⁹W. H. Guertin, "Differential Characteristics of the Pseudo-feeble-minded," American Journal of Mental Deficiency, 1950, LIV, pp. 394-398

²⁰Grace Arthur, "Some Factors Contributing to Errors in the Diagnosis of Feeble-mindedness," American Journal of Mental Deficiency, LIV, 1950, pp. 495-501.

However, it is somewhat questionable if this theory applies to the increased test results in these cases. In general, new admissions are tested within the first month of residency at the institution. It is doubtful if any marked degree of improved life adjustment is attained this soon. The effect of the more or less benign environment is probably operative, but it is difficult to prove to what degree, if, indeed, it is at all.

One factor which might be significantly operative in improved test results is that of the increased ability of the psychological examiners at Lapeer to obtain the optimum results from a subject who functions at an apparently lower level than do most patients tested in community facilities. Their experience with retarded persons might contribute to a more easily established rapport with these patients and therefore enable them to get a more accurate appraisal of their true potential.

Disposition of the Cases Following Admission

Usually within the first month following admission, cases are presented at a staff meeting for diagnosis, classification and planning. The social history, medical history and results of physical and psychological examinations done at Lapeer are used in these staff meetings. At such a staff meeting, the thirty cases of this study were all diagnosed not mentally defective. It is the intended purpose of the remainder of this paper to determine what happened to this study group following the above-mentioned diagnosis.

To accomplish this, case records were studied to determine

activities up to December 31, 1959. This allowed a minimum of three years movement for each case and it was felt that in this length of time, appreciable movement could be seen. Particular focus is upon the fact that some of the group have been discharged, while a substantial number have not. It is intended that some of the determining factors that lead to discharge will be identified. Also, the role of the social worker in relation to this group of not mentally defective patients will be examined.

For purposes of this study, it is assumed that any patient at Lapeer who is diagnosed not mentally defective is, therefore, an inappropriate patient for that facility. This is, of course, in accord with the law, but should also be accepted from a clinical and administrative standpoint. On this premise, then, a value is placed upon a plan that will lead to the discharge of such a patient. It has been the practice of the staff at Lapeer to endeavor to accomplish all discharges in a manner that will not be detrimental to the patient, his family or the community. Planning for such a discharge becomes the responsibility of the social service department almost exclusively. The role of the social worker, then, is very important in relation to this group of patients.

A review of these patients' records as of December 31, 1959, immediately divided the group into two distinct classes: those who were still patients at the institution and those who had been discharged. These two groupings will be examined separately and compared with each other to endeavor to identify the factors that brought successful discharge.

Of the thirty cases, eleven were still patients. Nineteen had been discharged. Two of the nineteen had been transferred to other institutions: one to Pontiac State Hospital as a psychotic and one to Fort Custer State Home, another state institution for mental defectives. This means that after over three years had elapsed, more than one-third of the group was still in residence at Lapeer. It might be noted that one of the patients discharged did not go to the community or to an appropriate setting, but simply to another state home for defectives.

In identifying factors which would lead to discharge, the first to be considered would be the recommendation of classification staff. It might be assumed that with a diagnosis of not mentally defective there would be a recommendation of discharge. However, the study indicates that in only twelve cases was such a recommendation forthcoming and in the remaining sixteen cases, some type of program for care or training at Lapeer was planned. It might then be predicted that where staff recommended discharge, such a plan was followed. This was not always the case. Three cases of the twelve are still in residence. Where a residential program was originally recommended, half of the group of sixteen have been discharged.

In subsequent staff meetings in the ensuing three years, five more cases were recommended for discharge and were released. Also, three patients still in residence had the original recommendation of discharge repeated, but release was not effected. In summary, it would appear that staff recommendations of discharge are not essential to discharge and cannot always be followed through when they are made.

There seems to be little relationship between staff recommendation and predictability of successful discharge.

It was felt that institutional adjustment might have some bearing on whether or not a patient would be discharged. However, it could hardly be predicted whether good adjustment would lead to discharge or maladjustment would bring more staff attention and ultimately discharge. When the resident and discharged groups' records were examined for notations of misbehavior and lack of general adjustment, four of the eleven residents showed such aberrations as did seven of the seventeen discharged patients. Such misbehavior consisted of escapes and attempted escapes and so-called "disturbed episodes." It would not seem, therefore, that institutional adjustment is a significant factor operating either for or against discharge.

Pre-commitment record of adjustment was examined to see if there was a correlation between contact with agencies, other institutions, a record of public misconduct and successful discharge planning. It was felt that if a patient had been known to agencies, had resided in other institutions and had a record of misconduct, it might be more difficult to return him to the community than to discharge a patient who did not have such a record. Examination of the data reveals that forty-seven percent of the discharged patients and fifty-five percent of the resident patients had been known to other agencies. Regarding previous institutionalizations, seventy-six percent of the discharged patients had been in some residential facility as compared to sixty-four percent for the resident group. These figures indicate that a history of

previous agency contact or institutionalization does not mean that it will be more difficult to return the patient to the community. This is reinforced by the fact that of the discharged patients, forty-seven percent had a history of public misconduct, while in the group of resident patients, only nine percent of the group had such a history. The area of pre-commitment adjustment, then, does not offer a significant degree of predictability as to what kind of patient is discharged.

It seemed that it might be predicted that if the family had jurisdiction of their child and were interested enough to commit him to Lapeer, this interest would also permit them to take the patient back home if such a plan were in the best interests of the patient. Perhaps, then, a patient would have a better chance of discharge if his family had petitioned for commitment. This theory is not supported by the study, however, for seven such cases were found in the resident population and eight such in the discharged group.

Admission ages were checked in the two groups and only a slight variation was found. The mean age of admission of the resident group was approximately fifteen and eight-tenths years, and the range was from nine years to twenty-four years. This compares to an admission age of about seventeen and two-tenths years and a range of from eleven years to twenty-five years for the discharged group. It is not felt that this slight increase in range and mean age could be a significant factor in determining successful discharge.

There is also a slightly higher mean intelligence quotient for the discharged group. They ranged from seventy-three to ninety-four and

had a mean of eighty-two and six-tenths. The resident group ranged from seventy to ninety-three and had a mean score of seventy-nine and three-tenths. The difference of three and three-tenths intelligence quotient points can hardly be considered to be a significant determinant of discharge.

It was decided to examine the group of discharged patients by themselves and to identify the significant factors surrounding their discharge. There was a wide variation in the length of time in residence for the group. The range was from twenty-two days to 1,156 days. The mean was 460 days. This represents a considerable expenditure of time and money and would seem to be an unjustifiably long time in which to effect a discharge. This is especially true when considered in the light of an admission diagnosis that indicated the patient was inappropriately placed from the beginning.

With the exception of the two who were transferred to other Department of Mental Health facilities, all the discharged patients were rated, at the time of discharge, according to their capabilities as follows: not capable of self-support; capable of partial self-support; capable of self-support. This represents an estimation of immediate potential capabilities rather than appraisal of an existing employment situation. Of the seventeen, one was capable of only partial self-support, four were not capable of self-support at all, while the remaining twelve were discharged as being capable of self-support. This does not mean, however, that they were discharged to be entirely independent. Actually, only two of the group were discharged

under such conditions. One patient escaped not long after admission and staff discharged him as capable of self-support. The other case was one in which community employment had been found for the patient and after demonstrating his success on the job, he, too, was discharged as being capable of self-support.

The remaining fifteen discharged patients went with some member of their family at the time of discharge. From this fact, it might be concluded that an interested family, willing to assume responsibility for a patient, is a significant factor in effecting discharge, even though the patient is not mentally defective and probably capable of self-support. In seven of these discharges, the family was assuming responsibility at the time of release when they had not been responsible at the time of admission, in that they were not the petitioners for commitment.

To begin to determine the role of the social worker in effecting discharge, the program from which the patient was discharged was noted. Of the nineteen discharged, two went to other state facilities, and one was discharged from escape, as previously noted. Nine patients were discharged directly from institutional residence. The remaining seven were discharged while in a program for which the social service department is responsible. Four of these were on a placement program in the community: three in home placement with relatives and one in work placement. Three patients were discharged while on visit with relatives. In less than half of the discharges, then, were the patients involved in a distinctly social service supervised program.

It was then decided to review all the available case records of this study group to determine the amount of contact each patient had with a social worker. Particular attention was given to the number of interviews held, both with the patient and with others regarding the patient, and to the frequency of these interviews. In some instances, correspondence of an especially significant nature was counted as an interview. An example of this would be a letter to a family or the court of commitment in which assistance with plans for discharge of a patient was requested.

To aid in the determination of factors leading to discharge, it was decided to consider the study group in three parts: the group who were discharged; the group in actual residence within the institution; and the two who were involved in one of the placement programs. Of those discharged, only seventeen of the nineteen cases could be used, because of the absence of the folders of the two who were transferred to other facilities. The two patients on placement included one on family care and one on home placement.

In tabulating the interviews, it was assumed that each patient was interviewed on the day of admission. While this interview is not recorded in any of the records, the assumption is in harmony with the admission policy of the social service department. It was not assumed that any other interviews were held and only those recorded in the patient's record were counted.

It might be predicted that the discharged patients were seen by their social worker more times and with greater frequency than were the

patients who have not been discharged. The study indicates that the resident patient's mean number of interviews was four. They ranged from one to seven interviews. Of the two patients on a placement program, one had twelve interviews and the other had twenty-two interviews, for a mean of seventeen. The patients who were discharged showed a range of interviews from two to twenty-seven. The mean number of interviews was slightly over nine.

The increased number of interviews for the two patients on a placement program needs some consideration to place them in the proper perspective with relation to either of the other two groups. One patient is one of the two cerebral palsied patients found in the study. Within five months of the time of his admission, he was returned to the care of his family on home placement. However, it is assumed that when the family can no longer care for him he will need to be returned to the institution, as there is no other appropriate state residential facility for his care. The other placement patient is on family care and attending public school. In similar cases in the past, such patients have been maintained on family care until the completion of high school, at which time they can be discharged as capable of self-support. This patient went on family care within one month of the time of admission. These two cases, then, represent situations where considerable social service activity is entailed, but in which the focus of the activity is not on discharge planning. It then becomes difficult to compare the activities devoted to these patients with either of the other two groups without skewing the conclusions and clouding the facts.

The significant fact of the number of social service interviews is that the discharged group show more than twice as many contacts as do the resident group.

It was felt that the frequency of contacts with the social worker might be significantly different between the resident group and the discharged group. The two patients on placement showed a mean time lapse between interviews of two and five-tenths months. The resident patients, on the mean, had one interview every five and seven-tenths months. The discharged patients had a mean time lapse of one and eight-tenths months. The mean time lapse between interviews, then, was over three times as great for the resident patients as for the discharged group.

The activity of the social worker seems to be a highly significant factor in the discharge of these not mentally defective patients. However, it is not clear as to why these patients were chosen by the social worker for this increased activity. Direct staff referrals for discharge planning does not account for all of these, but for some of them. However, of the resident patients who have been referred by staff for discharge, there is an increase of only one additional interview over the mean number for the remainder of the resident group and the frequency of interviews is slightly lower. It does not appear that staff referral is the answer as to the increased social service activity.

With case loads varying from 350 to over 1200, it is conceivable that chance plays a role in determining what patients are seen more frequently by social workers.

From the data available in this study, it is not possible to identify the factors that cause increased social work activity, but it can only be stated that the discharged patients show a significant increase in number and frequency of contacts with the social worker.

To get some indication as to the specific function of the social worker, each recorded interview was identified in one of the six categories suggested by Berkman.²¹ These categories were: (1) interpretations of the patient's illness, treatment, and surrounding problems, (2) assistance with problems of family relationships, (3) supportive treatment, (4) psychotherapy, (5) help with concrete problems, (6) interpretation to and liaison with other agencies. It was anticipated that the majority of the interviews would fit within the first two classifications, a limited number within the category of supportive treatment and none within the category of psychotherapy.

The validity of the evaluation of the interviews for such classification purposes is questionable, as it was done by the writer with no comparison against the classification of the same interviews by a group of social workers. Probably for this reason, a large percentage of the interviews are seen as not falling into any one class but into combinations of from two to three categories.

As classified, the results indicate that the largest percentage of interviews crossed the lines of any distinct classification and contained

²¹Tessie D. Berkman, "Practice of Social Workers in Psychiatric Hospitals and Clinics," American Association of Psychiatric Social Workers, New York, 1953.

elements of up to three different types. This group represented about thirty-five percent of the total.

The next largest category consisted of thirty-one percent of the total and was identified as being interpretation of illness, treatment and surrounding problems.

Help with concrete problems and interpretation to and liaison with other agencies were nearly equal categories, the percentages being eleven and ten, respectively.

As expected, no series of interviews that could be identified as psychotherapy was noted. Only ten percent of the interviews came under the heading of supportive treatment.

Help with problems of family relationships accounted for the remaining three percent.

Perhaps the most significant thing presented by this classification is that only ten percent of the interviews were devoted to supportive treatment and no practice of psychotherapy is noted at all.

CHAPTER V

SUMMARY AND IMPLICATIONS

Through the writer's personal knowledge of the Lapeer State Home and Training School, it was apparent that a number of patients who were not mentally defective were being admitted each year. While there were general impressions among staff members as to who these patients were and how they had come to be committed, no effort had been made to gather objective data regarding this group and their management. Because of the acute shortage of space for the care of appropriate patients, it seemed to the writer that a study of the inappropriate patient was in order. If means could be found to discharge the patients who were not mentally defective and to prevent commitment of this type of patient in the future, the institution could utilize its space and staff for the originally intended purpose.

The study proposal was to take all patients who were admitted during one calendar year that were diagnosed not mentally defective and ascertain their identifying characteristics and determine what happened to them following their admission. Thirty such cases, admitted during 1956, comprised the study group.

All information was gathered from the Statistical Division of the Department of Mental Health and from the case records at the Lapeer

State Home and Training School.

The group consisted of twenty-three males and seven females who ranged in age from nine through twenty-five. The age range was significantly narrow and the majority of the cases were adolescents at the time of their admission.

A high percentage of the patients demonstrated an inadequate social adjustment prior to admission. Nearly half had been known to social agencies, and nearly one-third had a history of public misconduct. Ten percent of the group had required the protective services of a children's agency. Twenty-three percent of the patients were also known to psychiatrically oriented agencies.

This group of inappropriately placed patients had a high instance of previous institutionalizations. Two-thirds of the group had been in residential care prior to coming to Lapeer. Twenty percent had been in Boys' Vocational School and thirty-three percent had been in juvenile detention homes. Thirteen percent came to Lapeer from other psychiatric facilities. These figures indicate that this group of patients had presented problems of a social or psychiatric nature before entering Lapeer and that a careful diagnosis of the basic problem was either not done or was so difficult and complex that the proper treatment plan was not clear and an inappropriate referral resulted. It is also possible that referring agencies are not clear as to what constitutes an appropriate patient for Lapeer.

To further explore the extent to which these patients had constituted a community problem, a tabulation of petitioners for commitment

was made. This showed that in only half the cases was a family member the petitioner. This suggests that in fifty percent of the commitments, an authority figure in the community was acting in lieu of the parents. It might then be assumed that the parents had abdicated their rights or that the patient's antisocial behavior had placed him in under the jurisdiction of a community authority.

In summation, then, a significant percentage of patients demonstrated an inadequate social adjustment as indicated by contacts with social agencies, and residency in other institutional settings.

The significance of psychological testing in the determination of mental deficiency is great. It might be assumed, then, that before a patient is committed to a state institution for mental defectives, he would receive a psychological test and that he would test within the defective range. Examination of the data reveals that in eight cases, no such testing was done. In nine cases, the pre-commitment test indicated that the patient functioned above the level of what is considered appropriate for Lapeer. In the remaining cases, the tests were within the mental defective range. It would seem that commitments are made without objective testing in some cases, and in some instances are made when the test results contraindicate such planning. An appreciable difference is noted between test results obtained in the community and those at Lapeer. The entire study group tested above the defective range and scored from seventy through ninety-four, following their admission. The increase ranged from four through twenty-four points and the mean gain was 14.95. No single theory could account for

this universal increase. Slow mental maturation would apply in some cases and improved general life adjustment might account for the increase in others. The varying ability of the examiners to gain rapport with the patients might also be considered.

Of the thirty non-mentally defective cases admitted in 1956, eleven were still in residence at the conclusion of this study on December 31, 1959. Of those discharged, two had been transferred to another state institution. A clear policy for disposition of these cases was not in evidence, as recommendations for discharge were not always followed and a substantial number were discharged when some type of residential program had been recommended. There was little relationship between staff recommendations and predictability of successful discharge.

An effort was made to determine what factors did contribute to discharge. To do this, the resident group and the discharged group were compared. Institutional adjustment and pre-commitment adjustment did not offer areas of predictability, as significant instances of poor adjustment were found in both the resident group and the discharged group.

There was no significant difference in either age or measured intelligence of the two subgroups.

In examining social work activity with the two groups, a significant difference is noted. The resident group had less than half as many contacts with the social worker and these contacts came with less than one-third the frequency of those of the discharged group. Increased social work would seem to contribute significantly to successful discharge.

The major role of the social worker seemed to be in the area of interpretation, both to patients and to families. Only ten percent of the activities could be identified as supportive treatment and no psychotherapy was practiced.

Of the discharged group, length of residency ranged from twenty-two days to 1,156 days. At the time of discharge, slightly over seventy percent were considered to be capable of self-support. However, about eighty-eight percent were discharged to the care of an interested family member.

The most significant factors, then, that lead to discharge of the not mentally defective patient are those of consistent social work practice and an interested family to accept the patient.

This study suggests several implications for current practice.

Community agencies could begin to adapt their policies so that they could serve more effectively the client who tests in the borderline defective and dull normal ranges. In this, they could follow the lead of the public schools in the metropolitan areas where they have expanded their services to meet the needs of this group. Indications frequently are that many agencies see institutionalization as the most appropriate answer whenever mental deficiency is suggested. If such practice exists, it is apparent that a large segment of the population that might test between seventy and ninety are going to find no services available to them. This is especially true of psychiatric services, where the patient is "too bright" for a state home and training school and "too defective" for in-patient or out-patient psychiatric services.

Inasmuch as more than one-fourth of the cases of this group received no pre-commitment psychological testing, it might be recommended that all prospective patients be tested to prevent inappropriate commitments. It is also significant that in no case was the staff at Lapeer consulted prior to commitment as to whether they felt they could serve the prospective patient. Also, of those who were tested, such a large number scored above the range of Lapeer's appropriate patients that it seems obvious that the community is not aware of the real purpose of the facility.

The whole method of court commitment could be held up to serious question. By such procedures, it is possible for patients to be committed to a state institution without ever having been seen by anyone with special knowledge or diagnostic skills in the area of mental illness or mental deficiency. When a commitment is made, it is necessary that the patient be admitted, whether he is an appropriate patient or not. Even if the patient is obviously not mentally defective, he must be admitted. Refusal of admission is contempt of court. Once a patient is admitted, it is very difficult to return him to the community. Use of the voluntary admission procedure,²² which is already provided for in the law, would make it necessary for the medical superintendent of the institution to approve of all applications for admission. This would eliminate the forced admission of inappropriate patients.

²²Michigan, Act 151, Public Acts (1923), as last amended by Act 235, Public Acts (1945) Section 9a.

It is recommended that some procedure of standard operation be made effective in institutions for mental defectives. This would need to begin by a definition in the law as to what constitutes a mentally defective person and what diagnostic procedures would be utilized to arrive at a diagnosis of mental deficiency. The Department of Mental Health should then interpret this to the institutions of the state in terms of what constitutes an appropriate patient. Policy and means to effect the policy should be established to effectively discharge the inappropriate patient.

To more effectively serve the community, Lapeer should establish an out-patient and pre-commitment service. Such a service should utilize the services of a physician, a clinical psychologist, a psychiatric social worker and a consulting psychiatrist. It should be the practice of this team to screen all referrals for possible commitment to determine eligibility and appropriateness of the prospective patient. Such screening should always precede commitment. If voluntary admission procedures were used, this team would act for the superintendent in approving or disapproving admission. This team would be responsible for consultation services both to the courts and to all community agencies. With interpretation and support, agencies could help maintain many patients in the community. For instance, one of the state-wide agencies offering foster care for children should be able to take over the non-defective family care patients who are attending public school. Further, if families received as much support to keep their child as they do to commit them, many prospective patients would

never need to be institutionalized.

Finally, the services of psychiatric social workers should be used more appropriately in intensive work, both with the patient and with the family. It is apparent that most discharges of not mentally defective patients are contingent upon an interested family and consistent social service contacts. It could be predicted that increased casework, then, could enable more families to become interested and more inappropriate patients to be discharged.

To determine the magnitude of this problem of inappropriately placed patients in Michigan's institutions for mental defectives, further research is indicated. A simple tabulation could be done by the Statistical Division of the Department of Mental Health. Further intensive study should be undertaken to determine the reasons why these patients are not returned to the community. This need is especially great because of the large waiting list of appropriate patients who need care in these facilities.

More research in this area within the institution need not be done if steps are taken to prevent the admission of such patients in the future and if continuous intensive effort is made to discharge the non-mentally defective patients now in residence.

APPENDIX A

Number _____ Name _____ Sex _____

Previous Agency _____

Previous Institution _____

Public Misconduct _____ Environment _____

Petitioner _____ County _____

Precipitator of commitment _____

Date Admitted _____ Age on admission _____

Intelligence Quotient _____

Diagnosis _____

Staff Recommendation _____

First Program _____

Present Program (12-59) _____

Institutional Adjustment _____

Date Discharged _____ Capability _____

Program From Which Discharged _____

To Whom Discharged _____

APPENDIX E

Name _____ Date Admitted _____

Social Service Interviews By Date

With Patient

With Family

With Others

Before
Placement

After
Placement

BIBLIOGRAPHY

Books

- Jervis, George A. "The Mental Deficiencies," American Handbook of Psychiatry, ed. Silvano Arieti, New York, Basic Books, Inc., 1959, Volume II, 1289.
- Kanner, Leo, A Miniature Textbook of Feeble-mindedness, New York, Child Care Publication, 1949.
- Lawrey, Lawson G. Psychiatry for Social Workers, New York, Columbia University Press, 1952.
- Masland, Richard, Sarason, Seymour, and Gladwin, Thomas, Mental Subnormality, New York, Basic Books, Inc., 1958.
- Noyes, Alfred, Modern Clinical Psychiatry, Philadelphia, W. B. Saunders Co., 1953.
- Perlman, Helen Harris, Social Casework, Chicago, University of Chicago Press, 1957.
- Rose, Arnold M., Mental Health and Mental Disorder, New York, W. W. Norton and Company, Inc., 1955.

Articles

- Arthur, Grace, "Pseudo-feeble-mindedness," American Journal on Mental Deficiency, 1947, LII, pp. 137-144.
- _____. "Some Factors Contributing to Errors in the Diagnosis of Feeble-mindedness," American Journal on Mental Deficiency, 1950, LIV, pp. 495-501.
- Benton, Arthur L., "The Concept of Pseudo-feeble-mindedness," A.M.A. Archives of Neurology and Psychiatry, 1956, LXXV, pp. 379-388.
- Berkman, Tessie D., "Practice of Social Workers in Psychiatric Hospitals and Clinics," American Association of Psychiatric Social Workers, 1953.

- Cutts, R. A., "Differentiation Between Pseudo-Mental Defectives with Emotional Disorders and Mental Defectives with Emotional Disturbances," American Journal on Mental Deficiency, 1957, LXI, pp. 761-772.
- Garfield, Sol L. and Affleck, D. C., "A Study of Individuals Committed to a State Home for the Retarded Who Were Later Released as Not Mentally Defective," American Journal on Mental Deficiency, March, 1960, LXIV, pp. 906-915.
- Guertin, W. H., "Differential Characteristics of the Pseudo-feetle-minded," American Journal on Mental Deficiency, 1950, 54, pp. 394-398.
- Williams, Ruth, "Casework With Defective Delinquents," American Journal on Mental Deficiency, 1956, 61, pp. 413-418.

Reports

- American Association of Mental Deficiency, Statistical Manual.
A Report Prepared by the Committee on Nomenclature, 1957.
- Group for the Advancement of Psychiatry, Basic Considerations in Mental Retardation: A Preliminary Report. A report formulated by the committee on mental retardation, New York: Group for the Advancement of Psychiatry, 1959.
- Heber, Rick, "A Manual on Terminology and Classification in Mental Retardation," A monograph supplement to the American Journal on Mental Deficiency, Sept. 1959, LXIV.
- World Health Organization, The, The Mentally Subnormal Child, The World Health Organization Technical Report Series, 1954, LXXV.

Public Documents

- Michigan, Act 151, Public Acts (1923), as last amended by Act 235, Public Acts (1945).