Part I.—Original Articles.

THE LAW AND THE PRESENT POSITION OF PSYCHIATRY.

THE PRESIDENTIAL ADDRESS DELIVERED AT THE NINETY-FIFTH ANNUAL MEETING OF THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION, HELD AT FOLKESTONE, JULY 1, 1936.

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MY first duty is to thank you for the honour you have conferred on me in electing me President, and to welcome you all on your visit to East Kent and Folkestone for, I think, the first time in the history of the Association.

As the subject of my address, it seemed to me that it might be well to take a review of the history of our Association and consider recent progress in the treatment of mental disorder, both from the medical and the legal points of view. We live in an age of great change. Many of us are in a world differing in almost every way from that in which we first saw the light. In addition to the changes, there is an increase in worry and anxiety, a liability to rush forward without due thought before action, since owing to the increased facilities for communication, greater and quicker results are expected, and we cannot react quickly enough to satisfy those who have no knowledge of the many difficulties of our work.

In 1772 Edmund Burke said: " The ground for a legislative alteration of a legal establishment is this: that you find the inclinations of a majority of the people (concurring with your own sense of the intolerable nature of the abuse) are in favour of a change. If this be the case in the present instance, certainly you ought to make the alteration that is proposed to satisfy your own consciences and to give content to your people. But if you have no evidence of this nature, it ill-becomes your gravity, on the petition of a few gentlemen, to listen to anything that tends to shake one of the capital pillars of the State and alarm the body of your people upon that one ground, in which every hope and fear, every interest, passion and prejudice, everything which can affect the human breast, are all involved together ". This caution might, I think, be very useful to-day.

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Through the kind help of our Hon. Librarian, Dr. Whitwell, I have obtained a short history of the Association, and I thought it would be interesting to record this and to consider what problems we have to meet at the present time, and how we are equipped to meet them. To do this, we must consider the present laws under which we work, together with such changes as are projected or have recently come about, and to what extent these latter are fulfilling the intentions of those who introduced them.

On June 19, 1841, a circular notice was sent out to " all Medical Men attached to Public Lunatic Asylums ", signed by Dr. Samuel Hitch, Medical Officer, Gloucester County Asylum. This circular suggested the importance and desirability of forming some bond of union, seeing that " these Institutions were the true school of mental pathology, and that periodic meetings for interchange of experience and opinion were of importance and value ".

A meeting was held at Dr. Hitch's house, with Dr. Shute in the chair, and thus the *Association of Medical Officers of Hospitals for the Insane* was founded on July 27, 1841. Dr. Hitch was appointed Hon. Secretary and Dr. Shute (his colleague at Gloucester) Hon. Treasurer. Dr. Blake, of Nottingham, was the first Chairman.

In the list of original members are to be found many names of note—Sir Alexander Morison, Dr. Pritchard of Bristol (afterwards one of the original Commissioners in Lunacy), Dr. Conolly and Mr. Gaskell (later also Commissioners), Dr. Munro, Dr. W. A. F. Browne, Dr. Shute, Dr. de Vitré, Dr. Charlesworth, Dr. Sutherland, Dr. Kirkman, Dr. Corsellis, Dr. Thurnam, and Dr. (later Sir Charles) Hastings, of Worcester, who had already, in 1832, founded the " Provincial Medical and Surgical Association ", which later (in 1856) became the British Medical Association. The first annual meeting was held at Nottingham Asylum in November, 1841, Dr. Blake being in the chair.

In 1844 the annual meeting was held at the York Retreat, Dr. Thurnam being Chairman for that year. It was on this occasion that it was suggested that the Association should publish an official journal, and a resolution to that effect was unanimously accepted. On July 20, 1852, at the annual meeting held at Oxford, Dr. Wintle being Chairman, it was decided on the motion of Mr. Ley (Hon. Treasurer), seconded by Dr. Thurnam, that a journal to be called *The Asylum Journal* should be produced, and Dr. Bucknill was elected Editor. It first saw light on November 15, 1853—a modest journal of 16 pages, royal octavo—*price 6d*. In 1855 it changed its name to *The Asylum Journal of Mental Science*, and in 1858 became *The Journal of Mental Science*.

The title of the Association was in 1841, " The Association of Medical Officers of Hospitals for the Insane " ; in 1853, " The Association of Medical Officers of Asylums and Hospitals for the Insane " ; in 1865, " The Medico-Psychological Association " ; in 1887, " The Medico-Psychological Association of Great Britain and Ireland " ; and in 1926, " The Royal Medico-Psychological Association " (Charter dated March 13).

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It is established, I believe, as an historical fact that this Association in point of time takes precedence of any other devoted to psychiatry in the world; its formation was followed closely by a similar Association in France, in America in 1844, and in Germany in 1864.

Up to July, 1855, each number of *The Asylum Journal* was headed by the following caption—

> "*Si quid novisti restius istis Candidus imperti, si non his utere mecum.*"
> Horace (*Epistolae*).

or in English—

> "If you have within your knowledge anything better, sincerity calls upon you to impart it, if not join me in taking advantage of what is here."

In 1854 Dr. Browne, of the Crichton Institution, was the first to give a definite course of lectures to attendants and nurses. He gave a course of thirty lectures. In 1884 Dr. Campbell Clark published a paper in the Journal showing that he gave lectures regularly and held examinations, and gave first and second class certificates to the successful candidates; a prize and medal for nurses has now been founded in his memory.

In 1885 the first edition of a *Handbook for the Instruction of Attendants on the Insane* was published by the "Medico-Psychological Association", and in 1890, in the Journal for October, there appears the Report of the Committee on Nursing of the "Medico-Psychological Association of Great Britain and Ireland" to the 49th Annual Meeting held at Gartnavel on July 24th. At this meeting (Dr. David Yellowlees, President), it was decided:

(1) That a system of training should be instituted.

(2) That three months' probation should precede the period of training.

(3) That examinations should be held in May and November, by paper and viva voce.

(4) That certificates should be granted to the successful candidates signed by the Examining Superintendent and an Assessor.

The number of entrants has in recent years grown immensely, so that thousands sit yearly for our examinations which have, together with the text-books published by us, a recognized standing all over the world. Alas, it is true that a prophet is not without honour save in his own country, and it is in England itself that the examination and the recognition of the certificate are resisted the most; in spite of this it must be admitted that we very much more than hold our own.

There is a matter which must again be brought up and considered, and that is the one-portal system for all nurses. We recognize the value of combined training in general and mental nursing, but are we sure that the nurse trained in mental hospitals gets an equal chance under the present conditions? What to the general nurse is a matter of daily routine is to the

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mental hospital trained nurse something that has to be specially learned, not through her own fault, but because the majority of our patients enjoy good physical health, and do not want to live in a general hospital ward atmosphere.

Another matter that has been to the fore recently is the relationship of physical and mental health. The sphere of the Medical Officer of Health has been greatly enlarged by the Local Government Act of 1929, and it is now often suggested that mental health should come under his purview also. I sincerely hope that such a project, while it is attractive in many ways, will not be brought into effect too rapidly, and I think there is much to be said against it at present.

The recent taking over of the municipal hospitals, and the problems arising therefrom, especially in backward areas, will need plenty of thought and planning before things run smoothly and give the results that all hope for and there is more than enough for the Medical Officer of Health to do. Meanwhile from the mental health side there is much reason for delay. There seems to be a prospect of advance in knowledge and treatment which would surely be hindered if any attempt were made to fix things at the present time. Do we really know what we want? Mental hospitals in the past were placed in the most inaccessible spots, and it is in many districts impossible to suggest regular attendance of out-patients there, and yet it is surely there that the best results are likely to be attained and the best opportunities for medical officers of these hospitals to obtain experience of all kinds of mental trouble. We know that treatment by Freudian analysis requires attendance by the patient at least five sessions a week and possibly for a period of six months. Admittedly in the present state of our knowledge Freudian analysis appears to be of little value in the psychoses, but is this due to failure on the part of the operator, and are we to cut off all chances of experience in this matter?

This same location difficulty will always militate against easy co-operation between mental and physical health authorities. While it is generally considered that a large proportion of the cases attending surgeries of general practitioners are purely mental in origin (e.g., gastralgia, debility and headache), is it practicable at the present time to treat them otherwise than by medical means? Can either doctor or patient give the time for psychotherapeutic treatment and would the results in general be any better?

There appears to be some increase in the public interest in the treatment of mental disorder, and more steps are being taken to teach psychology and psychiatry to the medical student, but even so it must be admitted that the general interest is still very small. How often in talking to a member of the lay public does one find him or her initiate the subject of mental disorder except that when it is thought one might be able to produce something humorous. There is very little endeavour to obtain acquaintance with conditions prevailing in mental hospitals, and quite recently in *Punch*, a

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picture appeared suggesting that medical officers viewed a crowd of patients in a pit from a gallery surrounding the ward. There is a great misunderstanding of what patients are like and of the nature of mental disorders.

The press publication of the verdicts of "suicide while of unsound mind" and the attempted pleading of insanity as a defence in murder trials lead to a very real and increasing fear of those of unsound mind. In a recent publication of memoirs by a well-known detective, an attempt is made to excuse the failure of the police to catch all murderers by saying that 7000 "lunatics" are discharged from county asylums annually. He also states that as the perpetrator of a particularly brutal murder was known to be "incarcerated for life" in a county mental hospital, it was decided to take no further action. It goes without saying that such misstatements made by one who ought to know better do infinite harm.

Unfortunately in most county councils, mental hospital committee work is not popular and is not sought after with the same avidity as is that of other committees. Mental hospitals entail expenditure, often very heavy, with nothing dramatic to show for it. Owing to fear, many persons are seriously upset by visiting wards and patients and cannot bring themselves to talk freely at all; consequently they only hear about the things that go wrong inevitably, and form an entirely false conception of these matters. In some areas centralization is being carried to an extreme degree and the difficulties of administration are very much increased—many patients because of unsound mind blame their own officers and cannot understand the reasons for delay in what appears to them to be a matter of high importance, but to a centralized officer is only an item in a list of wants he considers already much too long.

I always regret any attempt to run a group of hospitals on exactly similar lines, since this baulks all chances of progress and prevents new lines of approach to our problems. In his memoirs, Sir James Wilcocks, the eminent engineer who was in South Africa towards the end of the Boer War, tells us that early in the campaign the Boers used to cut telegraph wires, but ultimately they refrained from doing so. Instead they repaired any found needing such attention, for experience had shown that the hampering effect of central control on local initiative was advantageous to them as enemies.

Sterilization of the unfit is another subject that has been much to the fore recently. We are here beset on one side by those who have no interest in the welfare of the individual patient, but whose sole desire is to prevent the birth of anyone likely to become chargeable to the rates, and on the other side are those who think to benefit the sufferer, his possible progeny and the welfare of the race.

To the first I would say that in this age of increasing comforts "What shall it profit a man if he gain the whole world and lose his own soul?" I remember hearing Dr. Goodall say, "The Ancients had no problem of the

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chronic insane ", but where are these nations now ? Is it really desirable that the weakly should be removed and that nothing that checks luxurious indulgence should be permitted ? Are we sure that the result will be as expected ?

To the other side I would say, " Dare we ? What do we really know about inheritance and heredity ? What do we know about the effect of prolonged labour, use of forceps, etc. ? Have we records of families with no redeeming feature, with no useful member ? What do we know of regeneration ? " Had our ancestors practised this sterilization of the unfit, in 1817, instead of every effort being made to produce an heir to the throne, steps would have been taken to prevent the birth of Queen Victoria.

The Brock Committee considered both physical and mental ailments and also another very important question, namely, the ability of the diseased parent to bring up children properly. It was definitely recommended that voluntary sterilization should be legalized for the mentally defective and *those who have suffered from mental disorder*, sufferers from or carriers of a grave physical disability, and persons likely to transmit mental disorder. This is a very careful report ; it emphasizes that sterilization should be regarded as a privilege and not a punishment. In regard to those who have suffered from mental disorder, unfortunately the children have often been born before the parent's attack occurs. It has been suggested that sterilization is not necessary ; that nature is dealing with the matter in accordance with Morel's law of anticipation, and this was supported by Mott's work. Paterson has recently shown that this work is open to criticism owing to the way the material was collected. I can only say that my personal experience does not extend beyond seeing three generations affected mentally.

It is stated in the Brock report that only three of the witnesses were definitely against sterilization, but at the time of the inquiry there had not been sufficient activity in the matter to lead those against it to seek to give evidence. It is notoriously difficult to get anyone to take much active interest in maintaining the *status quo*, and it is because of this that the activities of those interested and of cranks often obtain undue recognition, as witness the Prohibition Act in the U.S.A. The history of sterilization is too short for any deduction yet to be drawn from the experience of foreign countries ; 27 years is the longest—in California—and it is only in this State that much activity has taken place.

To return to the treatment of those of unsound mind. Recently at the Mental Hygiene Congress, the Chairman of a Mental Hospitals Board stated that the greater part of the patients for whom his Board was responsible were patients because of economic needs. I do not think that anyone with practical experience will agree with this, in fact, it is surprising in how few cases admitted can poverty be ascribed as a cause. I only wish the matter were so simple. The real surprise is the number of those in good circumstances who take

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advantage of the public mental hospital work. The really "idle" rich are much more likely to be mentally affected than the poor. Occupation therapy is not new. It has recently been developed (and perhaps over-developed) in a way not always suitable to every class of life. It should always aim at production of something that is of value to the patient in after life.

We have worked for many years under the Lunacy Act of 1890, a wonderful Act which for many years has run smoothly and has permitted great progress. It was passed primarily to protect the liberty of the subject at a time of great public agitation against alleged unlawful detention; yet it has greatly facilitated the proper medical treatment of patients. The voluntary boarder section, at one time managed with great suspicion, began to develop, and has led to the Mental Treatment Act and the extension to the public mental hospitals the power of admitting voluntary cases.

The dealing with those of unsound mind by inquisition has nearly died out, and it is interesting to note that a very large proportion of cases are dealt with under Section 16 as requiring relief for their proper care and maintenance instead of, as was undoubtedly intended, under Section 13, e.g., as not under proper care and control. It was enjoined that a magistrate should see every case, and in rate-aided cases he must see the patient before admission, and in petition cases, if he does not, the hospital authorities must, unless under exceptional circumstances, notify and allow the patient to see a magistrate; but for those admitted under Section 13, there is no such provision.

It is a matter of surprise to many that while three members of the committee may discharge a patient, and two may hand him over to his friends for care, yet a patient cannot be allowed out on trial or leave without the authority of the medical officer in writing; but when one comes to consider this carefully, it is a very wise provision. It prevents illegal and unjust detention, but requires sufficient certainty on the part of those acting and a full sense of responsibility for what they are doing before a patient can be allowed facilities for damaging himself, dissipating his property or endangering others.

To me it has always seemed a pity that more use is not made of the boarding-out section in England; admittedly it is rather narrow in what it permits, but it still has many advantages over the more frequently-used Section 79, since it allows supervision to be maintained over the patient, financial help to be given, and settles his place of domicile.

It is very interesting to note that Section 79 works as well as it does. The relatives or friends give *an undertaking*, usually in writing, to look after and protect the patient, but as soon as the Committee have signed the order of discharge, he is completely free and no one has any right to interfere with him in any way; but though this provision works well, it would be better that the boarding-out principle with its beneficent supervision should be applied.

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I should now like to consider the Mental Treatment Act of 1930. Everyone will admit that this Act makes very considerable progress, but all must regret that in some ways it has not quite come up to expectation.

Sections 1 to 4 deal with voluntary cases. This, on the whole works very well, but difficulties arise owing to the chargeability of patients to certain areas, since no one can compel a voluntary patient to transfer to his own county or borough mental hospital. If that county will not pay for him as an out-county patient, there is no course open but to discharge the patient. It seems to me that the Board of Control might be given some special powers in dealing with such cases.

Another difficulty is this: A voluntary patient who loses volition cannot be retained for more than 28 days. Now many patients who know their mental hospital, who know that they are going to have another attack, realize that they will probably lose volition for a longer period than this, and it seems a pity that they cannot remain voluntary patients, as they desire, until they recover or recovery is hopeless. It may be considered impossible to allow persons who commit themselves and later lose volition to be retained indefinitely, but there could be some form of report on voluntary patients to the central authorities from time to time with reasons given for maintaining the voluntary status if the patient becomes non-volitional, and it seems desirable. The voluntary status is much appreciated both by patients and their relatives, and it seems very hard to have to alter the classification, perhaps only for a few weeks.

Section 5 created a new class of patient, but in some ways in county mental hospital districts has failed to produce the wished-for results. The word *temporary* seems to convey to the average practitioner an idea that the case is of a light, so-called borderland nature, while cases of the severe nature intended to be dealt with in this way are regarded as of necessity requiring certification. It seems that some other name will have to be found indicating more clearly the kind of case to be so dealt with.

Another difficulty arises, namely the power of sufficient detention provided by the extension periods; the medical officer is required to state when extension is applied for that the patient is still incapable of volition; now many cases recover volition some time before they are fit for discharge; some of course also obtain insight into their condition and are willing to remain on a voluntary basis, but a good many are only anxious to get away, develop a restless hyperactivity and undo all that has been done for them, and have to be certified for a short period.

Section 6 deals with the powers of local authorities. It seems a pity that an option was left as to the carrying out of certain provisions of the Act. Accommodation for temporary cases must be provided, but the reception of voluntary cases is optional. Treatment of out-patients and provision of after-care are also made optional—surely no one can doubt the necessity for

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making these compulsory. Reséarch is also very indefinitely provided for. I should have liked the central authorities to have the power to arrange for research in mental disorder, make use of the facilities already provided in mental hospital services and to co-ordinate these and prevent overlapping.

" Experimental work is entirely outside our province." This was published in the press as the dictum of the chairman of one of the largest mental hospital committees in the country. The circumstances with which the committee were dealing were certainly exceptional, but it is terrible that those who did not know the circumstances might regard this as a guiding principle for general use.

Section 11 deals with the Board of Control. Are we satisfied with it? I think not. I hasten to disclaim any disapproval of its members, but I deplore the cheapness with which the State has attempted to supply itself with co-ordination in the supervision of mental disorder. I think older members all feel the want of touch that existed with the original Commissioners in Lunacy. I feel that there is a loss in the absence of Honorary Commissioners from the Board, and in the lack of co-operation with the rest of the profession.

The provision for the protection of certifying medical men under Section 16 is a great advantage. The urgency orders, while of advantage, do not appear to be much required in public authority work.

Section 20 abolishes among other things the use of the word " lunatic ", (a beneficent provision in consideration of the popular use of the word), but curiously retains the phrase " criminal lunatic ". We are taught by the legal profession that a " sane mind " is necessary before anyone can be a criminal, so that the word lunatic is retained in the one case in which its use would appear to be legally unjustifiable.

This now leads to the question of criminal responsibility. The Atkin Committee recommended that the McNaghton rules should be altered to allow " uncontrollable impulse " to be pleaded as a cause of non-responsibility, but I, for one, am very glad that this course has never been adopted. Admitted that such impulse does exist, is it capable of proof in open court? I think not. Section 2 of the Criminal Lunatics Act gives a way out by quiet careful consideration being given by expert advisers to the Secretary of State.

And now to our Association. Are we to imitate the Royal Society, and say, " No opinion to be given as a body ", or are we not bound to assist development in the care and treatment of the mentally afflicted? If we must advise are we best constituted to do so? Can we benefit all types of members, the superintendent, the assistant medical officer, and others interested in our speciality? Should not the Research and Clinical Committee and the Mental Deficiency Committee be organized as Sections and be free to arrange their own subjects and programmes and, apart from the annual meeting, the times of meeting?

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Could not the Council, with Educational, Parliamentary and Library Sub-Committees, hold quarterly meetings? Are not the divisional meetings developing too much into social gatherings, and ought not medical officers to be given more freedom and encouragement to attend these meetings? You will have noticed with pleasure the formation of an Indian Division, and I hope this is a prelude to further such action overseas.

I think that the necessary developments are taking place. At this meeting for the first time, the scientific programme has been arranged by the Research and Clinical Committee and the Mental Deficiency Committee. I hope that this will be a big step in the direction in which I feel we ought to travel. At the same time we cannot shed our responsibilities as advisers to the health authorities—this is the function of a council formed from the various sections and committees. I would say that no one should give scientific evidence on our behalf, though we might nominate members qualified to give such evidence when requested, but that on administrative and legislative procedures we ought to be prepared to set forth our views.

I think I can close by saying that we have every right to be proud of our Association, its growth and its influence.

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