in common with each other (and with the originality of genius)—that they betray a weakening of the social bond. When this affects important conduct we call it *insanity* or *crime*. Indeed the fundamental conception of insanity might be stated as "social incompatibility," and the prime task of psychiatry is to discover its causes. Hence our concern with the mechanism of the social *rapport*, and hence the relevance to our task of the social sciences whose fundamental problem is the nature of this "social integration" of minds.

Dr. Ian D. Suttie has kindly consented to contribute to the pages of our Journal a series of critical notes calling attention to significant conceptions and developments in sociology, and suggesting their psychiatrical application.

Part II.—Reviews.

The Seventh and the Eighth Annual Reports of the Board of Control for the years 1920 *and* 1921.

Our review of the Report of the Board of Control (1) for the year 1920 could not be undertaken in time to be included in the volume of the Journal just concluded, and in the meantime the Report for the year following was issued, so we propose, as in the case of the Reports for the years 1917 and 1918, to consider them together.

The Board of Control, like every other part of our lunacy organisation, has been subjected to close scrutiny, amounting at times to fierce criticism. The Commissioners personally have had a troublesome time, and have shared with us an unusual measure of worries and anxieties. We are not much comforted by the reflection that an occasional shaking up is good for everybody. Such a reflection will have more point when we can feel that the tempest is over, and the current is with us and not against us. The future continues uncertain and reform is still talked about. We are not afraid of reform; we are as anxious as anybody that psychiatry should advance with the

(1) The Lunacy Act of 1845 (8 & 9 Vict. c. 100) constituted the Board of "Commissioners in Lunacy." The Lunacy Act of 1890 continued the "Commissioners in Lunacy." The Mental Deficiency Act of 1913 (Section 22, Subsection 4) constituted a body corporate by the name of "The Board of Control." These Acts did not extend to Scotland or Ireland as its jurisdiction is limited to England and Wales.

The Lunacy Act (Scotland) of 1858, the result of a Royal Commission which sat from 1855 to 1857, established the "General Board of Lunacy for Scotland," which became by virtue of the Mental Deficiency and Lunacy Act (Scotland) of 1913 the "General Board of Control for Scotland."

An Irish Lunatic Asylums Act was passed in 1845 and amended in 1847 and in 1898. The "Inspectors of Lunatics, Ireland," issued in 1921 their 68th Annual Report, which related to the year 1918.

times and keep abreast with the progress of medical science generally. But the reformer's zeal requires to be tempered with knowledge and wisdom. We may not always agree with the Board's policy and *obiter dicta*, but in the main it reflects the attitude and views of those most experienced in lunacy as regards England and Wales, and can be trusted to resist to the uttermost the attempts being made to stampede the Legislature into hasty and ill-advised measures of reform. The difficulties the Board of Control have to contend with are not always appreciated by critics. In the first place it has to see that the Lunacy Acts are adhered to, however much out of date or defective. Every recommendation it makes invariably involves finance, either local or national, and it has to be alive to the uselessness of clamouring for impossibilities. It also has judicial functions and many weighty responsibilities as regards the welfare of individual cases of certified insane, and must therefore move with calmness and discretion, having a strict regard to carefully ascertained fact. First thoughts can never be uttered, only the fruits of patient inquiries and serious deliberation. Those who complain that the Board of Control is not, as it were, the skirmishing party in advance of the general movement for reform, forget these facts. They forget that it has to occupy and administer any territory acquired, and thus of necessity needs to limit its reform policy to measures which have been decided upon only after mature consideration and close collaboration with those who by experience are best qualified to advise.

LUNACY.

Number of notified insane.—There has been an increase in the total number under care and treatment in England and Wales, approximately the same during both years, the increase being 3,580 for 1920 and 3,370 for 1921. This is rather more than that of the annual average (2,251) for the decade immediately preceding the war. The main cause of this increase is the continued low mortality-rate. The proportion of males to females is yearly reverting to that of pre-war times.

The total number of notified insane was 123,714 on January 1, 1922. The proportion accommodated in county and borough mental hospitals has now reached 78·7 *per cent.*, and the proportionate decrease in those cared for in registered hospitals and licensed houses continued. We have commented on this gravitation before—chiefly affecting patients of the private class—but it has occurred to us that it probably has some relation to the growth in the number of voluntary boarders, and does not point to any lessened activity of these latter institutions, but is rather an evidence of their virility, in that they are attempting as regards the better classes to provide that indoor treatment, under properly qualified specialists, of the neuroses, psycho-neuroses, and borderland mental cases, the need for which has been so long felt.

Voluntary boarders.—The following brief table shows the considerable growth which has occurred in the number of voluntary boarders treated in the registered hospitals and licensed houses :

	Registered hospitals.	Licensed houses.	Registered hospitals.	Licensed houses.
	Admitted.		Remaining.	
1901	149	124	87	59
1911	234	132	105	57
1921	330	315	165	127

It is the hope of our Association that this good work will in time be extended to the county and borough mental hospitals, and we look forward to the day when they will occupy another column in such a table as this. While on the subject of voluntary boarders, there is no doubt that the extension of this method of providing care and treatment will call for a better systematisation of its administration. As the Board point out in their report for 1921, complaints have arisen in various directions sufficiently serious to have induced the Board to issue a circular letter on the subject. Our view is that the ideal to be aimed for is to admit a neurotic or mental patient as a voluntary boarder for indoor treatment with the same freedom and lack of formalities as in the case of the admission of a patient into hospital for general diseases. The procedure should be the same for all mental institutions. It is worth taking risks to maintain this ideal, and we deprecate anything likely to prejudice or poison the patient's mind, and raise suspicions that there can be any doubt as to the voluntary nature of his admission and continued residence. The notice suggested by the Commissioners to be handed to every voluntary boarder on admission, at the foot of which is a declaration that he will abide by the rules and regulations for him to sign, appears to us to be free from objection. We also agree that certification should never occur at the hospital except under extraordinary circumstances, such as the patient having no relatives or friends, or having them they refuse to act. We would go further, and suggest that the relatives or friends should be notified that on twenty-four hours' notice being given they may be required to remove the patient and take all responsibility for his future care. We also suggest that under these circumstances the period of notice a patient is required to give of his intention to discharge himself might be extended to forty-eight hours. Another important question in this connection occurs to us, and that is, "When does a voluntary boarder become one who, within the meaning of the Lunacy Acts, ought to be certified?" It is generally understood that so long as a patient is(1) "sufficiently self-controlled and cognisant of his mental illness to enable him to seek treatment," although he be fully certifiable in other respects, he can be admitted as a voluntary boarder to registered hospitals and licensed houses.(2) It would certainly follow that he should also be capable of exercising his right to claim his discharge on giving twenty-four hours' notice. He may, however, enter a phase of his mental disorder during which he is no longer aware of his voluntary status and is incapable of claiming his freedom. Does he then become one who the law says should be certified in order that this indoor treatment may continue? It would appear so. Now when such a patient improves in mind and becomes cognisant

that he has been certified, might he not have good grounds for complaint? He could well say to the doctor, "You knew what my feelings were on this matter when I was last capable of expressing them, what grounds had you for supposing they had changed? I came here purposely to avoid the stigma of certification." It is obvious that this point will require the consideration of the Commissioners. The Board of Control ought, in such an eventuality, to be able to give legal sanction to the patient's retention for a limited period without certification, but with the relatives' or friends' approval if he has any.

Admissions, discharges and deaths.—The following table gives in brief the figures regarding these. For purposes of comparison those for 1919 are added:

	1919.		1920.		1921.	
Total admissions:						
Males	10,831	22,891	10,370	22,373	10,412	22,740
Females	12,060		12,003		12,328	
First admissions	19,328		18,659		18,584	
Discharges "recovered"	7,286		7,206		7,394	
Recovery-rate on direct admissions:						
Males	24·99%	31·83%	28·10%	32·21%	28·08%	32·52%
Females	37·97%		35·76%		36·26%	
Discharges "not recovered"	3,195		3,276		3,554	
Total deaths	12,069		8,504		8,543	
Death-rate:						
Males	14·42%	12·55%	9·90%	8·64%	9·35%	8·37%
Females	11·12%		7·65%		7·59%	

The admissions during 1920 and 1921 were respectively 533 and 816 above the average annual number of the previous ten years. The number of first admissions have, however, steadily declined. In 1914 they were 19,407, being 1,142 above the decennial mean. The years 1915–18 being abnormal years, they need not be considered in this respect.

Of the direct admissions during 1921, 18·5 *per cent.* had previously been discharged from mental hospitals.

Much attention has recently been directed to the recovery-rate in mental hospitals, and in a former review we drew attention to the fact that as at present calculated it was in our opinion without value medically and sociologically. At a meeting of the Section of Psychiatry (Royal Society of Medicine) on April 11, 1922, Dr. Bedford Pierce read a paper on "Recovery from Mental Disorder," and an interesting discussion followed. This discussion showed that our criticism was not made without good grounds. The problem of presenting a reliable recovery-rate is a difficult one, and not likely to be solved until our Statistical Committee is re-appointed and the whole matter of lunacy statistics readjusted and brought up to date.

The Statistical Committee which reported to the Association in

1904 did some really fine work, and established certain fundamental principles which are of the greatest value. However, " the Committee did not feel either that the time for this was ripe, or that the suggestion of a new classification really formed part of the task imposed upon them." They were no doubt right, but many of us have since felt that although a complete new classification was not possible, it was a pity that some definition of the scheduled forms of mental disorder was not attempted. Names are immaterial so long as we have some idea as to the type of case they referred to. Had this been done the re-classification in accordance with advancing knowledge of cases now recorded in our statistics would not have been an impossibility. The American Psychiatric Association has succeeded in formulating workable definitions of the main types of mental disorders in its statistical manual, and whether individual psychiatrists agree with them or not, when it comes to statistics each knows what the other is talking about. A recovery-rate which includes all forms of mental disorders is too unsound to be useful, and the time has come when the only real data of any value in this respect, *i.e.*, the recovery-rate of individual forms of insanity, should be available, and this is impossible until the mental disorders, however classified, are defined. Even if for this purpose only a few prominent types were separated out and defined and the remainder grouped together as unclassified, a beginning could be made. As other types became definable they could be added and their recovery-rate given.

This absence of definition of the scheduled forms of mental disorder destroys the usefulness and importance of some carefully compiled statistics to be found in the Board's report for 1921 on " Forms of Insanity in Relation to Etiology." This work might just as well have never been undertaken. For example, under confusional insanity obviously alcoholic insanity, toxic and exhaustion cases, senile confusion and dementia præcox have been returned. Mania and melancholia, which are treated as single entities, apparently cover every known form of mental disorder except perhaps general paralysis and epilepsy. Probably under delusional insanity every case of delusions from fixed ideas to paranoia finds shelter. What value can ætiological factors have when considered in relationship to such a *melée* of clinical types? The Commissioners could not have issued a more striking illustration of the correctness of their view that recent progress in psychiatry warrants a revision of nomenclature, and we trust that when this is done a definition of all terms used will be included.

Some interesting facts are given in the Board's Report for 1921 regarding the sex, age and mental condition in the direct admissions. The higher proportion of females admitted during 1920 was noteworthy. The proportionate distribution of sexes per 1,000 individuals is, as regards the general population, 476 males, 524 females. Of the direct admissions 1909–13 the proportions were 474 males to 526 females; for 1920 they were 459 males to 541 females. A comparison showed a considerable preponderance over the census figures of the direct admissions above the age of 35, with corresponding diminution at the earlier age-period. More married women were admitted aged

between 15 and 34 than married men, while fewer of the former were admitted between 65 and upwards. During 1920 there was a marked falling off in the number of general paralytics in both sexes, which was only partially accounted for as regards men by the reduced total number of males dealt with.

The ætiological tables for 1921 showed a reduction as regards insane heredity and alcoholism and a proportionate increase in prolonged mental stress as causes.

"Service patients" at the end of this year numbered 4,991—an increase of 318 on the previous year. The result of the re-classification of these cases in accordance with the terms of the Royal Warrant will be watched with interest—a matter which is already exciting much comment. We will then be in a position to know whether the number involved was worth the disturbance this loss of "service status" is creating: probably not.

The death-rate of the average number resident continues to decline, and for 1921 fell to 83·9 per 1,000, which is the lowest on record. We are not optimistic that the public will congratulate the mental hospital services on this fact. Not long ago they were taken to task for a phenomenally high mortality. No doubt some people were really much perturbed by it, but for the most part this fatality among the insane, mainly the outcome of war conditions, was used as a means to discredit the Board of Control. Many years will go by before the public generally will shed tears over dead lunatics. A low death-rate in the mental hospitals means an increase in the number of the insane the public authorities have to provide for, much to the distress of the economists. To us, whatever attitude the public adopts from time to time, the insane are sick people, and it is our duty as physicians to keep them alive and cure them whenever possible.

Dysentery and tuberculosis.—The continued prevalence of dysentery and tuberculosis in the mental hospitals is not creditable to us, and we agree with Dr. Shaw (*vide* p. 24) that the patients, and to a less extent the staff, should not be called upon to face the risks of infection and possibly death from these grave diseases. Dr. Shaw raises questions of considerable practical importance. His conclusions will need confirmation before they will be accepted, but we are sure that work on these lines is the only way to arrive at a solution of this difficult problem. It will be a great triumph for the medico-administrative authorities of the mental hospitals when the Board no longer needs to devote special sections of their Annual Report to the occurrence of dysentery and tuberculosis. As regards 1921, it was the first year since 1917 which did not show a marked fall in the incidence of dysentery. Tuberculosis also showed an increase.

Suicide and fatal casualties.—A remarkable paragraph appears among the Commissioners' remarks on suicides and fatal casualties. After commenting on the tendency at present to give patients much greater liberty and freedom than has been given in the past they go on to say: "The results of this greater freedom will, it is possible, lead to a larger number of attempts at self-injury on the part of patients who were not suspected of suicidal impulses, but we are

convinced that this evil is far outweighed by the greater good which will undoubtedly be felt by the many. In these circumstances we will do all in our power to assist medical superintendents in every possible way should any untoward event occur, including being prepared to give evidence at any inquiry that the greater freedom has been given at our express desire. We have no doubt that the medical staff will exercise all reasonable care in deciding to whom the increased freedom is given, and hope they will feel that they can exercise their discretion more happily, knowing that the Board will be at their backs in cases of accident."

This declaration is a courageous one, and the help of the Board on these trying occasions, happily few in number, will be welcome. We would like them to have gone a little further and included also the cases known to have suicidal tendencies, for no doubt the restrictions on personal liberty found necessary in these cases may operate against recovery and increase this distressing symptom. It is difficult to secure constant supervision that is not irksome to the patient, and the medical superintendent, as things are at present, has to shoulder sole responsibility for any relaxation of precautionary measures he thinks would make for recovery.

Half-yearly lists of patients.—The Commissioners in their Report for 1920 comment on the representations from several quarters as to the need for the half-yearly list of patients required by Rule 29 to be laid before the committee of visitors and a copy furnished to the Commissioners and to the clerk of the local authority. The medical staffs of the mental hospitals were not particularly interested in this return, which was a mere clerical matter. The Commissioners as far as they are concerned have abolished the July lists. It is understood also that no July lists are to be prepared for the Committee and clerk to the local authority. We would have been more than glad, however, to have been able to record that Rule 31 had been rescinded and the half-yearly parish returns abolished. We trust that the Board of Control Committee on Clinical Records will make some recommendations on this matter. A half-yearly clinical report to the parishes on every patient chargeable to them is a waste of the medical officer's time, and is probably considered so by most hospitals. The guardians require reports to be up-to-date to be of any practical value.

Financial matters.—Some comments made by the Commissioners at the beginning of their Report for 1921 have excited the ire of the Official Organ of the National Asylum Workers' Union. Recent numbers of this magazine have in consequence contained virulent articles attacking the Board of Control generally regarding its constitution and policy. Abuse is at any time but a poor substitute for argument, and we think that on this occasion much more has been read into the Commissioners' pious opinions than they were meant to convey. We cannot see how the Commissioners could help drawing attention to the increased cost of maintenance under the head of salaries and wages if they were to comment on this subject at all. The fact that the weekly salaries and wages in 1913–14 amounted to 3*s.* 2¾*d.* and by 1921 had reached 10*s.* 9⅞*d.* cannot be

ignored by a public department in the present state of the country's finances. After all, the reduction really foreshadowed by the Report was one which would follow on the fall in war bonuses based on the cost of living. However, we are bound to say that the comments referred to, however, might perhaps have been more happily worded. The nursing staff of the mental hospitals when it was miserably paid and the hours long no doubt cannot call to mind an occasion when any public body reported that " the whole subject of the work and wages of the nursing staffs in the mental hospitals requires to be very carefully considered." Now that nurses have reached their own as it were, they no doubt feel that such a comment is too post-dated to be welcome. To be fair to the Commissioners, this is not really so, for in their Report for the year 1918 they say—" They have for some time felt that the conditions under which asylum officers worked called, in many instances, for improvement not only in pay but in better provision for rest and recreation." Their interest in the nursing staff is primarily because " the comfort and health of the patients are largely dependent on the existence of a well-qualified and contented staff." The official mind, however, is prone to overflow its well-worn channels at times, and it was only to be expected that a comment from such a source that " Neither, in our opinion, do the long hours off duty, when they are almost bound to be spending money, tend to the contentment of the female staff, especially when they are far away from their own homes," would be regarded by those referred to as an impertinence and resented. Whether the Commissioners are right or wrong does not concern us, but neither they nor the mental hospitals authorities can claim to regulate the nurses' "off duty" existence except possibly during a limited period of their initial training. We are all, perhaps, human in this respect—that while we welcome a decrease in the cost of living, we cannot extend the same happy frame of mind to the decrease in pay which follows, and we are bold enough to think that the Commissioners in their rightful quest for economy will not recede from the position they took up in their Report for 1918.

On the general question, as physicians, we cannot altogether agree with the bald statement that the cost of maintenance of the patients in the mental hospitals remains very high. Although it is wonderful what is done for patients for 27*s.* 7⅞*d.* to 29*s.* 6½*d.* per week, progress cannot be recommended until the public are persuaded to still further relax its purse-strings. The Commissioners know this full well; their policy, if not their words, proclaims it. We would have preferred to see a statement that the care and treatment of the patients in the mental hospitals cannot be maintained at its present level at a reduced rate until the cost of living and the price generally of things are reduced, and that the public must be prepared for greater financial sacrifices if progress is to be made, and the reforms and betterments clamoured for by the medical profession and others interested in psychiatry, in the main blessed by the Commissioners, can come to pass.

(1) " Position of Psychological Medicine, etc.," C. Hubert Bond, *Journal of Mental Science*, October, 1921.—(2) Also to the Maudsley Hospital, London.

(To be continued.)

Report of the Commissioners of Prisons for the Year ended March 31, 1922. H.M. Stationery Office. Pp. 77. Price 2*s.* net.

This report is a publication of very great interest. It displays a change of view from that prevalent in former days, which, to one who, like the present writer, can look back upon many years spent in the prison service, seems almost incredible.

The report begins with certain statistics which show an increase in the receptions into prison over the numbers for the previous year. Much of this increase is, however, due to the larger number of debtors received, and the remainder is due to receptions on summary conviction. There was a slight decrease in the receptions for the more serious offences convicted on indictment. Post-war conditions and the unhappy prevalence of unemployment are naturally reflected in the receptions into prison. We notice that 11 *per cent.* of the receptions were sentenced to one week or less, and 24 *per cent.* to two weeks or less. The Commissioners remark that these short sentences "remain a standing difficulty." They would appear to be worse than futile. For, as the report says, "the deterrent effect of prison disappears with familiarity," and there is reason to believe that "the normal result of the short sentence is that the prisoner leaves prison with less fear of breaking the law than he had before."

But the main interest of our readers is in those aspects of prison life and administration which touch more directly upon the psychological side. (We say "more directly," because the whole question of crime and of the treatment of the criminal is, essentially, a psychological one, and there is no single point which can properly be divorced from psychology.) It is in this direction that the greatest changes are apparent.

We learn that during the year 101 persons were certified as insane during sentence, 231 were found to be insane on remand, and 55 were dealt with as insane at their trial. There were 85 cases certified as mentally defective during sentence, and 138 found to be so while on remand. And, in addition to these, 1,836 were remanded to prison for mental examination and report. The greater part of this work was, of course, done in the local prisons. And the report points out that these figures indicate the vast amount of highly responsible work which is entrusted to the medical officers of those institutions. Much work was also done in the estimation of the mentality of the younger offenders before their recommendation for Borstal treatment. But far more work of this kind should be done. The field has hardly been even scratched over at present. And it is mainly a question of staff. The report comments upon the fact that some of the American prisons possess a far larger psychiatric staff than is the case with us. We feel that, but for the present insistent demand for economy, the Commissioners would desire to increase the staffing of our own prisons in order to make them more comparable to those in America. And we may hope that the day will soon come when this can be done. After all, the true economy in this direction is to prevent people from coming into prison, and to improve them mentally when they are there. And this can only be done by intensive psychological in-

vestigation and treatment. We note that a "reception class" for all boys sentenced to Borstal treatment has been started at Feltham. In this class the boys' mental state is carefully estimated and their life-history is taken. This is eminently a step in the right direction. And it would be but a small extension to create such a class at some suitable prison for all prisoners with sentences of over, say, one year. They could then be drafted, as is done in New York, to whichever prison appeared to be most appropriate for each particular case.

We have also to train our examiners for the future. And in this connection reference is made to the successful post-graduate medical class on crime and punishment held at Birmingham University last summer.

There exists, say the Commissioners, a class of prisoner "whose mentality is not normal, but who cannot be certified either as insane or as mental defectives." No legal provision is made for these persons, although it is obvious that they cannot be treated under the ordinary prison rules. They present a grave problem. But there are many legal and administrative difficulties involved in its solution.

We are informed of many interesting innovations, of concerts, debates, lectures, of greater trust in the "honour" of the inmates, of outside visitors (women and men) for male prisoners, and of more associated labour during the evenings, in the long hours which were formerly spent by prisoners in their closed cells. The Commissioners feel obliged to defend themselves against the charge of "pampering" prisoners, whom, as they point out, it is our duty to restore to civil life as fit as when they were received therefrom. It is not likely that any of our readers will require such a defence to be made. But the idea that the proper treatment of an offender is by means of "the bread of affliction and the water of affliction" still lingers in the minds of some persons, even among our justices and law-makers.

We are pleased to see that the custom, suspended since 1914, of printing extracts from the annual reports of the governors, chaplains, and medical officers of the prisons, has been revived. These officials have spent their working lives among prisoners and have a first-hand knowledge of the problems involved. The fact that such extracts may be published will tend to increase the enthusiasm of these officers, and should add a new life and vigour to their reports.

We have only space to notice the more salient points in this report, but it is throughout full of interesting observations and suggestive comments. And we commend its study to all who are interested in these most vital psychological questions.

M. HAMBLIN SMITH.

Mental Deficiency (*Amentia*). By A. F. TREDGOLD, M.D., M.R.C.P., F.R.S.Edin. London: Baillière, Tindall & Cox, 1922. Fourth Edition. Demy 8vo. Pp. xx + 570. 31 Plates. Price 21*s.*

The third edition of this book, published in 1920, was reviewed at length in this Journal (*vide* vol. lxvii, 1921, pp. 52–62). It was there stated that Dr. Tredgold's work had for the most part received the seal of universal approval, and this has been borne out by the rapid