THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION'S MEMORANDUM OF EVIDENCE TO THE ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY*

PREAMBLE

1. The Council of the Royal Medico-Psychological Association wishes to thank the Royal Commission for inviting it to submit a memorandum of its views on the matters which the Commission is considering.

2. The Association now has over 1,300 members, representing every branch of psychiatric practice. Its work is organized in geographical Divisions, of which there are three in England and Wales, besides a Scottish and an Irish Division. For other purposes, the members are grouped in scientific Sections, for Clinical Psychiatry, Social Psychiatry and Psychotherapy, Child Psychiatry and Mental Deficiency respectively. The Association is governed by a Council consisting of the Officers, Representatives of the Divisions and Sections and additional nominated members, reflecting all aspects of the Association's work.

3. During the last few years the Association has given attention to the need for revised legislation in regard to both mental disorder and mental deficiency. In 1949 a sub-committee examined and reported on the provisions of the Northern Ireland Mental Health Act; in 1951, tentative proposals regarding mental deficiency were drawn up, and in 1953 similar work was done in regard to mental disorder and the psychopathic states.

4. The present memorandum of evidence has been prepared by a special committee of the Association, constituted as follows:

N. G. Harris, M.D., F.R.C.P., D.P.M., Physician for Psychological Medicine to the Middlesex Hospital; President-Elect of the Association (to be inducted on 14 July, 1954). (CHAIRMAN.)

Alexander Walk, M.D., D.P.M., Physician Superintendent, Cane Hill Hospital, Coulsdon, Surrey; Hon. Librarian to the Association; Co-Editor of the *Journal of Mental Science*. (SECRETARY.)

M. J. Brookes, M.R.C.S., L.R.C.P., D.P.M., Medical Superintendent, Shelton Hospital, Shrewsbury; Secretary of the Parliamentary Committee of the Association.

N. H. M. Burke, O.B.E., M.R.C.S., L.R.C.P., D.P.M., D.M.R.E., late Medical Superintendent, Cell Barnes Hospital, St. Albans; Chairman of the Education Committee and of the Mental Deficiency Section of the Association.

J. S. Ian Skottowe, M.D., M.R.C.P., D.P.M., Psychiatrist, The Warneford and Park Hospitals, Oxford; late Physician Superintendent, St. John's Hospital, Aylesbury; Chairman of the Parliamentary Committee of the Association.

G. M. Woddis, M.R.C.S., L.R.C.P., D.P.M., Medical Superintendent, The Coppice, Nottingham; Secretary of the Northern and Midland Division of the Association.

5. The reports of the previous sub-committees mentioned above were taken as a basis, and summaries were circulated to all members resident in England and Wales, while at the same time comments and suggestions were invited. The replies received were scrutinized and all suggestions were given full consideration. In regard to Mental Deficiency, this work was done by the Executive Committee of the Mental Deficiency Section. The draft memorandum was finally considered and approved by a special meeting of the Council of the Association.

6. The Council is confident that the views expressed here command general support and represent the most complete agreement attainable among the members of the Association.

7. Having thus set out the procedure by which the Association's evidence has been compiled, it is proposed, for the sake of convenience, to use the first person in the remainder of this memorandum.

GENERAL PRINCIPLES

8. When, in 1925, our predecessors in the Association gave their evidence before the Royal Commission presided over by the late Lord Macmillan, their leading proposals were designed to secure the provision of facilities for out-patient treatment and for the in-patient treatment of a considerable proportion of cases on a voluntary basis, both in mental hospitals and in special clinics to be established in connection with medical schools and general hospitals; further, they recommended that a provisional order should be instituted as an intermediary measure before resort to certification; and that the procedure for mental disorder should be dissociated from the Poor Law.

9. In general, the Report of the Commission, published in 1926, was in agreement with these principles, and the Report was welcomed by the Association as one in which "a broad

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vision and high ideals were blended with common sense and practicability". The Mental Treatment Act of 1930 gave partial effect to the Report's recommendations, and has been the foundation for all subsequent progress, but it has always been a matter for regret that it was not possible to introduce comprehensive legislation; so that, for certified patients, procedure is still governed largely by the Act of 1890, and a number of defects in this Act, which were pointed out in the previous Commission's Report, remain unremedied.

10. Legislative changes not directly concerned with mental treatment, particularly the Local Government Act of 1929 and the National Health Service Act of 1946, have enabled great progress to be made in the provision of psychiatric services. Out-patient centres are widely distributed; a psychiatric consultant service is available to most general hospitals and for other purposes; within the mental hospitals, where a large proportion of patients are voluntary, a liberal regime with a minimum of restrictions prevails. Classification of patients has in many instances been greatly improved by the provision of special admission and convalescent units, and the introduction of new methods of treatment has led to greater therapeutic activity everywhere. A great expansion of social work and after-care has been made possible by the development of the new profession of psychiatric social worker. The most striking advance is seen, perhaps, in areas where the mental hospital has become a centre from which a comprehensive psychiatric service is provided, and which enjoys the esteem and confidence of the public. A number of in-patient psychiatric units exist, mainly in the teaching hospitals, and a few well-staffed University departments of psychiatry, including the Institute of Psychiatry in London, have been established. On the other hand the mental hospitals have had to contend with the prevailing financial stringency and with a very serious shortage of nursing staff, with consequent overcrowding and a threat of a lowering of standards. Apart from this, there is insufficient provision, except in London, for the in-patient treatment of cases of neurosis and of children suffering from mental and nervous disorders of all kinds.

11. In the field of Mental Deficiency there was, between the wars, a large increase in the number of institutions and an expansion of Local Authority services, in accordance with the Mental Deficiency Acts of 1913 and 1927. Even in 1939, however, some counties had failed to provide any accommodation for defectives. The National Health Service Act of 1946 has enabled all parts of the country to share in the resources available. It is well known, however, that the number of beds provided falls far short of the demand. Within the institutions advances in general medicine have resulted in better care for the lower-grade patients, while the training and resettlement of the higher grades has been successfully pursued and has been favoured by present conditions of full employment. In this field, as in that of mental disorders, modern psychiatric thought lays stress on treatment aiming at the patient's return to the community.

12. New legislation should establish the principle of voluntary and temporary treatment for both mental disorder and mental deficiency, reserving the judicial order for as few cases as possible. But because of the more indefinite limits of mental deficiency and the doubt and misunderstanding which exist among the public concerning its nature and treatment, we think that in this field additional safeguards should be provided.

13. We believe that both for mental disorder and for mental deficiency mere amendment and consolidation would not adequately meet present needs, and we recommend that a new comprehensive Mental Health Act, covering the whole psychiatric field, should take the place of existing legislation. We give our recommendations for mental disorder and mental deficiency separately as Parts 1 and 2 of this memorandum.

14. Much attention has recently been given to the problems presented by persons suffering from forms of mental abnormality, not generally recognized as either certifiable mental disorder or as mental deficiency, but which nevertheless affect behaviour so as to render them delinquent or otherwise anti-social. Such persons are now commonly known as "psychopaths". Where the condition is severe, some measure of control is required for the protection of others, and all possible treatment should be given. We have included proposals for dealing with this type of patient in Part 3.

15. Much thought has also been given to the special problems of mental decay and other forms of mental disorder occurring in old age. We have discussed this subject in Part 1, as in general we believe that these problems can be solved by suitable arrangements within the framework of the general and mental health services, rather than by special legislation.

16. Throughout we have tried to simplify the present law, and to frame proposals which are practicable in present circumstances and which we hope will be acceptable to public opinion. We believe that any future legislation should be flexible enough to meet the needs of a great variety of individual sufferers, and to encourage a right therapeutic relationship between them and those who minister to their care and treatment.

PART 1

MENTAL DISORDER

TREATMENT IN THE COMMUNITY

17. The organization of psychiatric out-patient clinics is the responsibility of Regional Hospital Boards, and such clinics now exist at a large number of centres. There are still many districts, however, where the distance from the nearest clinic is too great for its use

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except as a diagnostic centre. The limitation of medical staffs and of psychiatric social workers makes further expansion difficult at present. This applies also to domiciliary services; where these have been effectively developed the demands for admission to hospital have been considerably reduced.

18. Recently new forms of community care have been provided in the form of therapeutic social clubs; and in a few places there are day hospitals, where various forms of treatment can be given without the need for admission as an in-patient.

19. Local Health Authorities are responsible for taking measures for the prevention of mental illness, for the care of patients otherwise than in hospital, and for their after-care on discharge from hospital. Clearly, however, the medical and social services provided from the hospital must be an integral part of such care and after-care. In the case of patients leaving hospital it is most undesirable that there should be any break in the continuity of treatment and support during the period of readjustment to normal life. Close co-operation between the local authority and the hospitals is therefore essential in the patients' best interests. The degree to which this now exists varies very greatly in different areas; we refer to this matter again under the heading of "Mental Welfare Officers". We recommend that the principle of co-ordination should be expressly recognized in future legislation, and that the authorities concerned should be encouraged to pool the staffs needed for the purpose, by way of joint appointments or secondment.

20. The work of the Mental After-Care Association should be supported, so that its activities can be extended to parts of the country where it cannot operate at present, and similar work should be undertaken directly by Local Authorities. There is a need for the establishment, in large centres of population, of hostels for patients capable of normal self-supporting occupation, but who have no families and for whom ordinary lodgings are unsuitable.

In-Patient Treatment Outside the Mental Treatment Acts

21. Treatment outside the Mental Treatment Acts is provided at a number of special units which are part of or connected with general hospitals, and in certain other special hospitals. Such are, for instance, the psychiatric unit of St. Thomas's Hospital; Woodside Hospital, which is part of the Middlesex Hospital group; Belmont Hospital; the Cassel Hospital, and the Park Hospital at Oxford. These deal entirely with cases of neurosis or of early or mild psychotic disorder; they are not subject to inspection by the Board of Control, and admission is without any kind of formality.

22. We regard the establishment of these special units and hospitals as a welcome development, which we should like to see extended, especially at University centres. In present circumstances, however, some caution is needed to ensure that such special units do not absorb an undue proportion of available resources in money and in medical and nursing man-power, to the detriment of the mental hospitals where the bulk of psychiatric in-patient work must continue to be carried out.

In-Patient Treatment Under the Mental Treatment Acts

Admission of Patients

A. Voluntary Patients

23. The admission of patients to mental hospitals on a voluntary basis has been an unqualified success, and the majority—in some hospitals, the great majority—of patients are now admitted in this way.

24. In the last few years it has been suggested that the necessity for making a written application, and the requirement that 72 hours' notice of departure should be given, act as deterrents to admission, and, experimentally, arrangements have been made for the admission of a certain number of "informal" patients. This has been done by declaring some detached part or unit to be a separate hospital outside the Mental Treatment Acts.

25. This scheme appears to be logical and unexceptionable when the building so used is genuinely separate from the main hospital and was designed and provided for the reception of cases of the type envisaged. It may, however, be detrimental if the building is one which was meant to be an integral part of the hospital, e.g. an admission unit equipped with facilities which were meant to be shared by the whole hospital. It appears, moreover, that in such cases legal subterfuges have been used, e.g. granting patients in the main hospital leave "on trial" to enable them to go to the "informal" division for special treatment. To overcome these drawbacks, it has been suggested that the law should allow of "informal" patients being admitted to any part of the mental hospital; or alternatively, that all voluntary admissions should be without formality.

26. We have come to the conclusion that it would be invidious for there to be two categories of voluntary patients within the hospital. In general, we favour the abolition of all formalities for the admission of adult voluntary patients; we recognize, however, that this possibility depends on whether discharge formalities can also be dispensed with. Undoubtedly, the deterrent effects of the need for a written application have been increased by the use of over-elaborate and clumsily worded forms, and therefore, we would strongly advise that if the present requirements are retained any form used should be of the simplest kind, containing only the barest words indicating the patient's wish to enter the hospital. Patients under the age of 16 should continue to be admitted as at present.

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27. We believe that no useful purpose is served by sending notifications of adult admissions to the Board of Control, and we recommend that this requirement should be abolished.

27a. We recommend also that the reference in Section 1 of the 1930 Act to the admission being "for mental illness", should be deleted, so as to remove any doubt as to the propriety of admitting cases not generally labelled "mental", e.g. cases of neurosis or psychopathy, of organic brain disease or of bodily illness thought to be of psychological origin.

28. Section 1 of the Mental Treatment Act lays down that a voluntary patient shall give 72 hours' notice of his intention to leave. It has, however, been held that in fact there is no legal sanction for detaining the patient during this time. We have considered whether it would be better to dispense altogether with this requirement. The experience of hospitals and units working outside the Acts seems to show that it is possible to deal with emergencies even in the absence of any statutory period of notice. If the mental hospital is designated for emergency admissions under the procedure proposed in a later section, it should be easy to deal speedily with cases where it would be unsafe for the patient to be at large. On the other hand, there are many cases where emergency action would hardly be justified, but where delay is desirable in order that the relatives may be sent for, or merely to enable the patient to change his mind. Total abolition of the statutory notice would certainly help to remove any feelings of constraint in the minds of voluntary patients, and on the whole we would prefer that the patient's discharge, like his admission, should be free from formality. If the statutory notice is retained, we think the period should continue to be 72 hours; but it should be clearly stated that a patient who expresses and maintains his intention to leave should be discharged within a specified time even if he does not give written notice.

29. On the other hand, we should like to see a reconsideration of Section 2 (3) of the Mental Treatment Act, which forbids the retention as a voluntary patient of one who becomes incapable of expressing himself as willing or unwilling to receive treatment. We have in mind especially the numerous patients who in the course of their stay in the mental hospital are overtaken by senility or by deterioration due to organic disease, so that their last months or years are spent in a state of mental decay. In such cases, to insist on a change of status is to inflict hardship on the patient and his family, and we think that the doctrine of the "continuing will" ought to be applied. A safeguard might be introduced here by laying down that where the patient is incapable of expressing himself, a relative should have the power to discharge him in the same way as for patients detained under order.

B. Temporary Patients

30. At the time of the previous Royal Commission, various proposals were put forward by this Association and other bodies for the institution of some kind of provisional order, and it was generally agreed that the full procedure of certification should be used only in the last resort. The Commission eventually recommended a provisional order not specially linked to the patient's mental state as regards volition. "Not without reluctance" they recommended that this order should be a judicial one. The Mental Treatment Act of 1930 however, made provision for temporary treatment on different lines; Section 5 of the Act was made to apply to "non-volitional" cases only, and the intervention of a magistrate was dispensed with.

31. It is well known that Section 5 has not been used to the extent that was hoped, partly because of its limited application, but mainly because there was no obligation to use it, the cases to which it was meant to apply remaining certifiable under the Lunacy Act; consequently, certification has been preferred in many areas as the simpler and cheaper procedure.

32. However, the twenty-three years' experience of the working of Section 5 has shown that admission to mental hospitals without judicial intervention is both practicable and acceptable to public opinion. A further indication pointing in the same direction is the designation, under the National Health Service Act, of mental hospitals as places of observation to which patients can be removed under Section 20 of the Lunacy Act. Neither provision has given rise to criticism or to complaints of improper detention.

33. On the other hand, there is ample evidence that judicial intervention is no real safeguard against undesirable and unnecessary certification. The Report of the last Royal Commission (Paragraph 93) deprecated the certification of physically ill people suffering from temporary delirium, and of old people in a neglected condition. Undoubtedly such certifications still continue.

34. We believe that the time has come to extend to all patients admitted to mental hospitals the benefit of conditions similar to those of Section 5, irrespective of their volitional state or of their supposed recoverability. We recommend that this should be the normal method of admission for patients other than voluntary ones and apart from the emergency procedure mentioned later.

35. The application should be made, as now, by a relative, or by the Mental Welfare Officer of the local authority, and there should be two medical recommendations, one given, if possible, by the patient's usual medical attendant, and the other by a specially approved practitioner.

36. Approval for this purpose should be given only to practitioners who possess special qualifications in psychiatry, or have at least had psychiatric experience. In the case of a patient to be admitted to a public mental hospital it should be permissible for the second recommendation to be given by a medical officer of the hospital itself. In many instances, in fact, this is highly desirable. Personal contact of this kind leads, wherever it is already

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practised, to a more judicious selection of cases and the diversion of many to voluntary admission or to out-patient or domiciliary treatment. In areas where recommendations are made by medical officers of observation units in general hospitals, they should work in close touch with the mental hospital to secure the same result.

37. In order to ensure that the highest possible number of recoverable cases should receive the whole of their treatment under this section, we recommend that the period of detention should be up to one year in the first instance, and that in cases where recovery is expected this period should be extendable by two further periods of six months on the authority of the Board of Control. In view of the right now possessed by the appropriate relatives to order a patient's discharge at any time, it seems unnecessary for the application for extension to be made by them or by a Mental Welfare Officer, and we propose that it should be made by the Medical Superintendent after notice to the appropriate relative.

38. Since "temporary" admission would, under our proposals be the rule and no longer the exception, we do not think that the special provision under Section 5 (9) and (10) of the Mental Treatment Act, for visitation and examination by two members of the Hospital Management Committee is necessary or desirable.

39. We have considered whether any additional safeguards ought to be provided to compensate for the abolition of the magistrate's order for all initial admissions. In our view, the patient's greatest safeguard lies in the integrity and skill of the medical and ancillary professions. We have moreover proposed the substitution of two medical recommendations for the present single certificate. A further safeguard now exists in the relatives' power of discharge. Nevertheless we think it reasonable that an unwilling patient should have better opportunities of stating his objections and it may be of securing a reconsideration of his case.

40. We propose, therefore, in the first place that the Board of Control should be strengthened so as to make possible a personal visitation of any case in which they may feel doubts as to the propriety of the patient's detention, or where letters received from the patient appear to show a reasonable cause for enquiry.

41. Secondly, we propose that all patients admitted under this section should be given the right of an interview with a magistrate unconnected with the management of the hospital. The patient should be informed of this right, and of his rights of correspondence, by means of a printed statement; this, however, should not have the appearance of a formal document, but should be incorporated in a leaflet or brochure giving general information about the hospital. After interviewing the patient, the magistrate would either endorse the application form, or else make a recommendation for discharge to the Hospital Management Committee.

C. Patients Under Judicial Order

42. As already stated, we recommend that the Judicial Reception Order should be used only for those who can no longer be retained as Temporary Patients, either at the end of 12 months or during the second year, where recovery seems unlikely; or at the end of two years in any case where further detention is necessary. It should, therefore, be permissible to apply for an order from a convenient date a short time before the expiry of the first year —say a fortnight—or at any subsequent time up to the end of the two years.

43. We propose that the order should be made by a specially appointed magistrate unconnected with the management of the hospital on the application of a relative, or of a Mental Welfare Officer after giving notice to the appropriate relative. There should be two medical recommendations, of which one should be by a practitioner specially approved (as in the previous section); in the case of a public mental hospital, he should preferably be one of the hospital staff.

44. We think that the opportunity should be taken to make changes in the terminology used, which we believe would go far towards removing the so-called "stigma" attached to the Judicial Order. This is largely bound up with the use of the words "certification" and "certified patient", which to many of the public suggest, however wrongly, the irrecoverability of the patient and his permanent incarceration. The term "person of unsound mind" is also objectionable, as being an epithet rather than a diagnosis. If the term is still needed for other legal purposes, e.g. in connection with civil incapacity, it should be defined in a separate clause of the Act as applying to one or more of the categories of patients recognized here. We suggest that the medical recommendation should state merely that the patient is suffering from mental illness, and that it is necessary for his welfare that he should remain under care and treatment; and the clinical reasons for this conclusion should be stated. To designate the patient's status, the word "certified" should be replaced by some innocuous term, such as "Reception Order Patient".

45. We recommend that Judicial Reception Orders, as at present, should expire at the end of a year, and should be renewable by means of special reports and certificates sent to the Board of Control. As the patient will already have been in hospital for at least a year before the order is made, the prescribed intervals might be altered so that the report would be required at the end of the first, third, fifth, seventh and tenth year after the making of the order, and thereafter at five-yearly intervals. The wording of the certificate should be altered to correspond with the new terminology of the order; and as the patient may be on leave at the time the report is made, we suggest that the certificate should be worded as follows: "that the patient is still suffering from mental illness and is not yet fit to be discharged from his present status". In order to assist the scrutinizing Com-

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missioner, we suggest that the report, in addition to describing the patient's present condition, should give a brief account of his progress since the last report was sent.

D. Emergency Admissions

46. Many cases arise in which it is necessary that the patient should be removed to hospital immediately. Under the existing law there are a number of different procedures for this. Some of these are little used, and the ones to be considered are principally the three-day order enabling a patient to be admitted for observation to a specially-designated hospital (Lunacy Act, Section 20, as amended in 1946) and the Urgency Order for the admission of a patient to a mental hospital (Section 11). Section 11 originally applied to private patients only, but since 1930 has been available to all patients. Section 20 originally applied to "pauper" patients, and the places to which they could be removed were the workhouses, later superseded by local authority hospitals. Since 1948, however, mental hospitals or parts of mental hospitals have also been designated under this Section. Apart from local difficulties, this has worked well, and we approve of the arrangement generally. There appears now to be no essential difference of purpose between the Section 11 and the Section 20 procedure, and we consider that there should be a single unified procedure for emergency admissions.

47. We recommend that the Mental Welfare Officer should have power to remove any patient in need of immediate care to a hospital designated for the purpose, either a general or a mental hospital. The order would cover three days, and would be extendable to twenty-one days on an order signed by the Medical Superintendent of the mental hospital or medical officer in charge of the observation unit.

48. We refer later to the position of Mental Welfare Officers, and to the arrangements which, on their own initiative, are being made for establishing a recognized course of training for entrants to this service. Assuming that such training will become general, we think that Mental Welfare Officers may properly be entrusted with these powers, and that there is no need to require that their action should be supported by a medical recommendation, although in many cases they will act on medical information.

49. We believe, however, that there are cases in which the patient's family are unwilling to call in an officer of the local authority, and would prefer to deal directly with the hospital. We recommend, therefore, that the same power to make a three-day order should be allowed to an appropriate relative or friend, who in this case should be supported by a medical recommendation, to be given by any medical practitioner.

50. We contemplate that in general all mental hospitals (including Registered Hospitals operating outside the National Health Service), would be designated, but there should be power to restrict the designation in particular cases at the request of the hospital, to meet, for instance, the needs of small hospitals or of those set aside for special categories of patients.

51. These provisions would make possible a limited period of observation under competent psychiatric care of patients in whose case a considered decision as to disposal cannot otherwise be reached. We summarize here some of the methods of disposal which are now available or would be made available under our proposals:

(1) Discharge home, as not in need of further treatment, or after successful emergency treatment. Referred, if necessary, to the patient's own medical attendant, or to an out-patient clinic, or to the after-care service of the local authority.
(2) Admission to a general hospital for treatment of bodily illness.
(3) Admission to a geriatric unit.
(4) Admission to a special neurosis hospital, or to a psychiatric unit of a general hospital.
(5) Admission to the mental hospital as a voluntary or temporary patient.
(6) Admission to a convalescent home.

We recommend that, where an observation unit is provided as part of a general hospital, its use should not necessarily be restricted to cases under order. It should be permissible to admit for observation without formality suitable patients who present themselves voluntarily, for instance patients who have made a previous recovery in the unit and who seek assistance there at the onset of a relapse.

E. Priority

52. At present, certified admissions have absolute priority over voluntary admissions, since the magistrate's order is a direction and not merely an authority to receive. Consequently, under conditions of overcrowding, it has often been necessary for mental hospitals to close their doors to voluntary patients, sometimes for long periods, although in fact a number of these may have been more urgently in need of care than other patients sent under order. Further, patients have been unnecessarily certified in order to secure their admission. We recommend that in future all admissions should be put on an equal footing, the Medical Superintendent being given the same discretion to decide on priority as is now enjoyed by the admitting officers of general hospitals.

Mental Welfare Officers

53. The duties in connection with mental treatment formerly carried out by relieving officers were by the National Health Service Act, 1946, transferred to officers of the Local Authority. This was done by substituting the words "duly authorized officer" for "relieving officer" wherever they occurred in the Acts; but no precise instructions were given to local

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authorities as to the appointment, qualifications and duties of these officers. Local authorities were left free to "authorize" officers belonging to any of the recognized professions, or specially recruited, and to require them to be engaged wholly in statutory duties under the Acts or to participate in other forms of mental health work.

54. There has since grown up a movement among the duly authorized officers and other mental health workers to organize themselves into a professional body under the name of "Mental Welfare Officers". This term has, therefore, been used throughout this memorandum.

The Association has recently conferred with the Society of Mental Welfare Officers with a view to establishing a national system of training for such officers, and it is intended to pursue the matter jointly with the Society of Medical Officers of Health.

55. The need for such a national scheme is apparent from the widely divergent views taken by local authorities of the functions of Mental Welfare Officers. In many areas there is close co-ordination between the local authority and the hospitals; here the Mental Welfare Officers co-operate with the medical staff of the mental hospitals and with their psychiatric social workers at out-patient clinics, in the patients' homes and at the hospitals as part of a comprehensive mental health service. Elsewhere, a much narrower view prevails; duly authorized officers are restricted to carrying out their statutory duties under the Acts and are largely out of touch with the services provided by the hospitals.

We are glad to know that the Society of Mental Welfare Officers endorses the wider conception of this work, and in framing our recommendations regarding the admission of patients we have assumed that this conception will prevail everywhere.

56. We suggest that practical recognition should be given to this principle of co-ordination by recognizing the mental welfare officer's right to obtain specialist advice, in conjunction where practicable with the patient's general practitioner; this would be done either by referring a patient to a suitable out-patient clinic, to which he should be conveyed if necessary, or by arranging for a domiciliary visit by a psychiatric specialist. Conversely, the Mental Welfare Officer should be required, when deciding on the action to be taken, to have regard to the opinion and advice which a psychiatric specialist may have given.

Protection of Persons Exercising Duties

57. The provisions of Section 16 of the Mental Treatment Act, 1930, have been generally effective in protecting medical practitioners and Mental Welfare Officers against unfounded litigation. Nevertheless, it would seem that the Section ought to be amended to include certain persons not now covered. Such are medical practitioners and psychiatric social workers who may give information to a Mental Welfare Officer upon which the latter takes action; or psychiatric specialists acting as consultants to observation units in general hospitals, who may give advice, but do not themselves write certificates or recommendations. Such persons might be held not to be doing "anything with a view to signing or carrying out an order etc.", or "anything in pursuance of the Acts". We therefore recommend that protection should be extended to all persons giving advice or information in a professional capacity in connection with procedure under the Acts.

Discharge of Patients

(a) Voluntary Patients

58. As already explained, we are recommending that a voluntary patient should be able to leave without having to give notice. If, however, the requirement that notice shall be given is retained, it should be made clear that this may be waived and the patient allowed to depart immediately, and on verbal request only, if the Medical Superintendent does not consider this detrimental. The Medical Superintendent should retain his present powers of discharging a patient on his own initiative.

59. We do not recommend any change in the procedure for the discharge of patients under 16 years of age.

60. If our proposal that a patient should be allowed to retain his voluntary status, notwithstanding his loss of volition, is adopted, then special provision should be made to give a power of discharge in such cases to the appropriate relative. This power should be exercised in the same way as in the case of temporary patients or patients under order.

(b) Temporary and Reception Order Patients

Discharge by the Hospital Authorities

61. Under the present law, discharge may be ordered by two members of the Hospital Management Committee on the advice of the Medical Superintendent. We do not think that this procedure accords well with the conception of the mental hospital as primarily a place of treatment and cure. Since, throughout his stay, it will have been emphasized to the patient that his detention is necessary to his welfare and will be terminated as soon as his state of health allows, it follows that the Medical Superintendent should be able to carry out this promise personally. Moreover, we think it undesirable that a patient should be required to appear before a lay committee whose members cannot be expected to know how best to discuss his case with him. We recommend therefore that the Medical Superintendent should have the power to discharge a patient of his own authority.

62. We think that the provision by which three members of the Committee may order

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a patient's discharge without the Medical Superintendent's advice should be retained, as being an established safeguard which may be of value in special cases.

63. We do not think that there is need for any difference in procedure according to whether the patient has recovered or not.

Discharge by Order of Relatives

64. Previous to 1948 the power of ordering discharge was possessed by relatives of private patients only, but by the National Health Service Act this power was extended to the "appropriate relative" of every patient. On the whole the change has been found beneficial; it renders discharge procedure more flexible, and has made for increased confidence in the hospital on the part of the patients' families. In framing our proposals, we have assumed that the system will be continued. On the other hand the use of this power unwisely may result in premature discharge with consequent harm to the patient, and no protection is given to the patient against a relative who may be ill-disposed towards him or at least unable to give him proper care.

65. We have considered whether any such protection ought to be given, for instance, by extending the grounds on which a barring certificate can be issued, as has been done in Northern Ireland. The present barring certificate refers only to a patient who is "dangerous and unfit to be at large", and though this is generally interpreted as including a patient who is dangerous to himself by reason of suicidal tendencies, it would seem that the clause had regard more to risks to the public than to the patient's interests. We think that the wording here should be altered to provide for danger *to*, as well as danger *from* the patient, such as danger arising from neglect or cruelty, and we recommend that the Medical Superintendent should be able to issue a barring certificate, on the same terms as at present, if he can state that in his opinion "the patient's discharge will lead to danger to himself or others". The relative should have a right of appeal to the Hospital Management Committee, and from them to the Board of Control.

66. We think also that the definition of the "appropriate relative" needs revision. It would appear that at present, in the absence of a spouse or parent, an unreasonable wish to order discharge on the part of one of the relatives must prevail against the unanimous opinion of all the others. It seems also that the relatives' power of discharge will need to be limited in the case of patients received under Section 30 of the Magistrate's Courts Act, 1952, since its exercise might make the magistrate's order of no effect.

67. The present provision of Section 79 of the Lunacy Act, by which any relative or friend (apart from the "appropriate relative") may apply to the Committee for the patient's discharge, should be retained, the wording of the undertaking being altered to accord with changed conditions.

Discharge to the Care of the Local Authority

68. Previous to 1948 the Poor Law authority had a duty to remove and maintain any patient who on discharge from a mental hospital might otherwise have been homeless. There is now no such duty on the part of the Local Health Authority; the hospital can only notify with the object of enlisting the Authority's help. We think it wrong that any patient should be retained in hospital solely because there is nowhere for him to go, and we recommend that Local Authorities should be required to admit such patients to appropriate accommodation under Part III of the National Assistance Act.

Leave of Absence

69. Different provisions apply to the grant of leave of absence to patients, according to whether they are private patients in Registered Hospitals or Licensed Houses, or patients of any class in public mental hospitals. Apart from short leave of up to 4 days, the former patients can be given longer leave on trial or for the benefit of their health; the latter may be granted leave on trial only. In Registered Hospitals leave is given by the "Manager" (i.e. the Medical Superintendent) with the concurrence of two members of the Committee; in public mental hospitals, by two members on the advice of the Medical Superintendent.

70. We think that these anomalies should be removed, since, among other reasons, patients of all classes may from time to time be in need of treatment which is best given or can only be given outside the mental hospital.

71. We believe that there is no need for any distinction between the different purposes for which leave may be granted, nor is it necessary to differentiate between short leave for holidays or with a view to early discharge, and prolonged leave of the nature of "boarding out". Moreover, we think it unnecessary that the Hospital Management Committee should be involved, unless there is a need for monetary assistance.

72. We recommend that the Medical Superintendent should have power to grant any patient leave of absence and to terminate this at his discretion. The grant of leave should be for a specified period of up to 3 months, renewable within the statutory time limits in the case of a temporary patient, and indefinitely in the case of a Reception Order patient, provided the Order itself is renewed as recommended above.

73. It is often necessary to send a patient for a short period to another mental hospital to enable some special investigation or treatment to be carried out. At present this is done by way of formal transfer, involving special transfer orders, and the full admission procedure,

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including the sending of notices and reports to the Board of Control, has to be gone through twice over. We recommend that it should be made possible to effect such temporary transfers by a grant of leave of absence from the sending hospital and without any formality on the part of the receiving hospital.

74. There is at present no provision for the grant of leave of absence to a voluntary patient, it being assumed that where leave is desired the patient will discharge himself and later apply for readmission. This involves unnecessary work in completing forms, making out new case-papers, etc. and moreover the procedure generally is disliked by the patients themselves. We recommend that voluntary patients should be allowed leave in the same way as others.

75. It is our hope that in future more use will be made of the procedure of "extended leave" to enable mild chronic patients to be boarded-out with relatives or friends.

76. The Hospital Management Committee should have power to make monetary allowances, within prescribed limits, to patients on leave. There are cases, however, where it is more appropriate for the patient's maintenance to be paid by the National Assistance Board, e.g. where the patient's family are already being assisted, or where the patient himself had been assisted before his admission to hospital. Moreover, in "extended leave" cases, the financial responsibility should always be undertaken by the Board, for, since hospitals work within a strictly limited budget, money spent on boarded-out patients would be at the expense of those remaining resident. It is important that in deciding on the amount to be allowed to the patients, the Board should have regard to the recommendations of the hospital authorities, to meet the special circumstances, medical or social, of each case; and it should not be necessary for the patient to make his own application for assistance.

Absence Without Leave

77. We think that the period of 14 days during which a patient absent without leave may be brought back might with advantage be extended to 28 days.

78. We recommend a change in the procedure for recapture. At present the only persons who may retake a patient are officers and servants of the hospital or other persons authorized in writing by the Medical Superintendent. Some doubt exists as to the powers of the Police, although commonly the Police are willing to act at the request of the hospital. There is no authority to lodge the patient anywhere pending the arrival of staff from the hospital; moreover, since he can only be returned to the hospital from which he is absent, much inconvenience and expense in time and money result whenever a patient finds his way to a distant part of the country.

79. We recommend, therefore, that power should be given to the Police and to Mental Welfare Officers to apprehend such a patient and for the latter to lodge him temporarily in any hospital designated for emergency admissions. It should, moreover, not be compulsory for the patient to be returned to his original hospital, and in cases where a considerable journey is involved, arrangements should be made for the patient's transfer to a mental hospital nearer to the place where he was apprehended, if there are no special reasons to the contrary.

Transfer of Patients

80. The present provisions governing the transfer of patients from one mental hospital to another are in general satisfactory. Much benefit has resulted from the abolition of chargeability, so that patients can now be moved freely for convenience of visiting or special treatment, although the present pressure on accommodation often means that transfers can only be effected on an exchange basis. Considerable difficulty still exists, however, in effecting transfers from one part of the United Kingdom to another, since orders made in one part of the Kingdom are not valid elsewhere. We recommend that the Act should include provisions enabling temporary or reception order patients to be transferred as required between England and Wales, Scotland, Northern Ireland, the Isle of Man and the Channel Islands, and, by treaty, to and from the Irish Republic. We recommend also that the procedure for the transfer of private patients should be simplified; in particular, it seems unnecessary that the previous consent of the Board of Control should be required.

Patients' Property

81. The existing provisions for the protection of patients' property while in hospital operate very satisfactorily in long-stay cases, and we should like to pay a tribute to the kindly and personal interest taken by the officers of the Court of Protection, of the Official Solicitor's Department, and of local authorities acting as Receivers, in the welfare of the patients with whom they are concerned. Nevertheless we consider that there is a great need for a simple and rapid interim procedure which can be brought into action within a matter of days from the time of the patient's admission. We have in mind cases where delay may mean grievous financial loss to the patient; for instance, where rent charges accumulate because no one has authority to terminate the tenancy although it is plain that the patient will never be fit to return to his home; or where a small business will lose all saleable value unless it is sold immediately or someone is appointed to manage it.

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Notification of Death to Coroner

82. The law at present requires that the death within the hospital of any temporary or certified patient shall be reported to the Coroner in a prescribed form, giving particulars of any unusual circumstances attending the death and of any injuries present at the time; this requirement does not apply to voluntary patients. It appears that in a number of areas the provision is interpreted by the Coroner as requiring him to investigate every death, and to have the relatives of every patient interviewed and questioned by his officer. This is a distressing and vexatious practice which we most strongly deprecate. It should be remembered that particulars of all deaths are notified to the Board of Control, and unusual circumstances are immediately notified to the Coroner in accordance with the usual practice of all hospitals. We believe, therefore, that statutory notification to the Coroner is unnecessary and undesirable, and we recommend that it should be discontinued.

Powers and Duties of the Medical Superintendent

83. The provision by which the medical officer or one of the medical officers of the mental hospital ("asylum" as it was then called), was to be its Superintendent was first enacted in 1853, and was the direct result of the exposure of evils and abuses which were found to be due to divided and confused responsibilities within the hospitals. Authority was given to the medical man in order that the function of the asylum as a place of treatment should be emphasized and its work co-ordinated from this point of view. In later years, Medical Superintendents often complained that Hospital Committees imposed upon them personally an undue amount of non-medical administrative detail, which would have been better delegated to lay officers. "Medical Administration" in this exaggerated sense is now obsolete. But the preservation of "Medical Authority" is, we believe, as necessary now as it was a hundred years ago, and for the same reason. This opinion was endorsed by the previous Commission, and we are in full agreement with the conclusions expressed in paragraphs 189 to 195 of their Report.

84. We have given consideration to another aspect of the Medical Superintendent's position, arising out of the better medical staffing of mental hospitals in recent years, and the enhanced status and clinical independence of the senior staff. It has been suggested that the Medical Superintendent's statutory responsibilities, in such matters as the discharge of patients or the writing of continuation reports, should be transferred to the medical officers in charge of individual cases. We do not advise this, for several reasons. It would, we think, be impracticable to define the professional standing or rank which would entitle a medical officer to undertake these responsibilities. "Consultant status" has been suggested, but it must be remembered that the hierarchical structure set up by the Minister of Health for the purpose of determining conditions and terms of service is liable to alteration at any time. It might also be difficult to decide who was the appropriate medical officer to carry out the statutory duty, for instance, in cases where a patient has been transferred temporarily from one department of the hospital to another in the interests of his proper classification or treatment.

85. We think it best that the Medical Superintendent alone should be referred to in the legislation; but it should be understood that this indicates his duty to ensure that the provisions of the law are carried out, rather than an obligation to act personally in every case. The principle of delegation is recognized in the Mental Deficiency Regulations, 1948 (Paragraph 6), where it is laid down that certain duties imposed on the Superintendent may be performed by some other person duly authorized by him. We think that this principle should be made of general application.

Licensed Houses and Homes

86. The previous Royal Commission was unanimous in recommending that the present system, under which a limited number of licensed houses exist, should come to an end; the members were divided as to whether these houses should be abolished altogether or should be placed upon a new footing. No action was taken on any of these recommendations, but the Mental Treatment Act of 1930 permitted the establishment of approved nursing homes for the reception of Voluntary and Temporary patients.

87. Since the admission of Temporary patients involves the element of detention, and since under our proposals the differences between the Temporary and the Reception Order patient will be still further diminished, there seems to be little purpose in maintaining the distinction between the approved nursing home and the licensed house, and we recommend that they should be amalgamated under a single designation.

88. Economic conditions in recent years have prevented the establishment of more than a few approved nursing homes, and have considerably reduced the numbers of licensed houses. Those that remain are, we believe, efficiently conducted and meet a real public demand. Some would be placed on an economically sounder footing and might be saved from extinction if they were allowed to extend their accommodation to provide for a larger number of patients; at present this is prohibited by Section 207 (5) of the Lunacy Act of 1890. We recommend that the disability should be removed, and this would follow naturally from the amalgamation of the status of these houses with that of approved nursing homes. We believe that the licensing or approving authority should in all cases be the Board of Control and that the

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establishment of new homes, as well as the enlargement of existing ones should be permitted. We suggest that approval might be for all categories of patients, or limited to certain categories only. In general we are in agreement with the recommendations made in Paragraph 244 of the previous Commission's Report as to the conditions under which homes might be approved.

Criminal Patients

89. Although the detention and care of "Broadmoor" patients is outside the terms of reference of the Royal Commission, we think it may be permissible for us to state our views concerning the admission of such patients to ordinary mental hospitals, inasmuch as their presence may be held to affect the welfare of other hospital patients. Further, we are putting forward proposals concerning certain patients not now classified as "Broadmoor" patients, but for whom we believe that special provision should be made.

90. In general we are satisfied that "Broadmoor" patients may continue to be admitted to mental hospitals by order of the Home Secretary. They are, for the most part, persons serving sentences for comparatively minor crimes, and had their mental disorder been present at the time of the offence, or arisen after their liberation, there would have been no question of the propriety of their admission to the mental hospital.

91. Local conditions, however, may make a particular patient unsuitable to be received in a particular hospital. We recommend, therefore, that in all cases the Medical Superintendent of the receiving hospital should be given full details of the case before the Order is made, and regard should be paid to any representations he may wish to make.

92. A proportion of patients certified while serving a prison sentence are detained at Broadmoor. When their sentence expires they cease to be "Broadmoor" patients, and are transferred to ordinary mental hospitals. We think that in future such transfers should be subject to the opinion of the Medical Superintendent of Broadmoor that the patients are suitable for ordinary mental hospitals, and if he considers them not to be suitable they should remain at Broadmoor under the provisions suggested below.

93. An anomaly which we suggest should be rectified is the loss by "Broadmoor" patients of the remission of sentence which they might have earned by good conduct had they remained in prison. This is generally felt as a grievance and causes discontent, which may easily spread to other hospital patients. We recommend that remission should be granted on a favourable conduct report by the Medical Superintendent.

94. The term "Broadmoor patient", which has been introduced to take the place of the former "criminal lunatic", is, we think, an unfortunate one. In the public mind "Broadmoor" implies murder and other crimes of violence, and mental disorder manifested by homicidal tendencies; but the prison patients selected for admission to mental hospitals are precisely the ones who are free from such tendencies. We suggest that some less misleading term should be used, such as "Home Office patient".

95. On the other hand, patients are from time to time admitted to mental hospitals who on common-sense grounds ought to be sent to Broadmoor or some similar institution. As an example we may take the case of a man who has served a sentence for attempted murder. Some time after his release he shows signs of mental disorder and is certified and admitted to a mental hospital. (It is even possible that he had been insane previously and had been detained at Broadmoor.) In hospital it becomes evident that his homicidal tendencies are again active, and his presence may cause great alarm to his fellow-patients as well as to the staff. Under the present law, nothing can be done until the patient actually attempts murder, and then the whole procedure of committal and trial must be gone through before he can be given the control and supervision which he needs.

96. This is in striking contrast to what obtains in the field of mental deficiency. Under the Mental Deficiency Acts, two large institutions receive violent and dangerous patients by simple administrative arrangement and without the need for criminal proceedings.

97. We do not suggest that anything on this scale is necessary in the field of mental disorder, since mental hospitals are well able to care for patients liable to ordinary outbursts of violence, but we think that in cases where there is a reasonable apprehension of homicide, or a homicidal attack has actually been made, the Board of Control should be empowered to order the patient's transfer to Broadmoor or some analogous institution. It is not expected that more than ten or twelve cases a year would need to be dealt with in this way. Similarly a patient already in Broadmoor and whose sentence expires should be retained there if he appears to be dangerous.

Mental Disorder in Old Age

98. The Association has in recent years given much thought to the problems of mental disorder and decay occurring in old age. In addition to research carried on by individual members, a special committee was set up in 1951 to study questions arising from the increase in the number of such patients in mental hospitals, and to make recommendations.

99. We wish to endorse the conclusions arrived at by the committee and its recommendations. An abbreviated version of its Report is submitted as an Appendix to this Memorandum.

100. It was never the intention that the County Asylum, later the Mental Hospital, should be used for the reception of patients showing mild mental decay in old age. Such persons were regarded as properly cared for in the workhouses and workhouse infirmaries, and their

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successors the public assistance institutions and the chronic wards of municipal and county hospitals. During recent years, however, there has been a serious reduction in such accommodation, due in the first place to the closing of old and obsolete institutions and the upgrading of infirmaries to hospitals dealing mainly with acute illness; and latterly to war damage and staff shortage. This has happened at a time when the aged population has become greater, both absolutely and relatively, and when various more or less unforeseen social factors, described in the Report, have favoured hospital rather than home care. The consequence has been the increasing use of the mental hospitals for this class of patient.

101. On the other hand, recent research has shown that a large proportion of patients in this age group suffer from mental illnesses quite similar to those occurring at earlier ages, and equally responsive to the skilled treatment given in mental hospitals.

102. It follows that facilities for careful observation and diagnosis are required, and that patients should be admitted to whichever type of hospital best suits their needs.

103. Cases of mild senile decay should be provided for, if able-bodied, in Local Authorities' Part III Accommodation; if physically infirm, in geriatric sections of general hospitals, or annexes connected with them. Cases of senile decay associated with severely disturbed behaviour are properly admitted to the mental hospitals, as also cases of mental illness (psychosis), such as depressions and delusional states, which are liable to arise in old age more commonly than is often supposed.

104. The admission to mental hospitals of large numbers of mildly demented old people leads to severe overcrowding and to the exclusion of other patients in need of active treatment, and these are the reasons which have prompted us to suggest remedies. We deprecate very much, however, any suggestion that the patients themselves are harmed or made unhappy by their environment in the mental hospitals. They are housed in separate wards and do not associate with cases of acute mental illness; they are looked after by nurses to whom their care is a welcome relief and change from their other duties. Their occasional disturbed behaviour is understood and tolerated. They appreciate the company, or merely the presence, of the young people whom they meet at associated entertainments. When physically ill they can be nursed in their own wards and often in their own beds.

105. The proposal is sometimes made that all patients over a certain age—60 or 65—should be entitled to admission to mental hospitals under some special legislative provision, and so be exempted from the "stigma of certification". We believe that such proposals are based on imperfect acquaintance with mental disorder as a whole, and are unjust to other patients who are equally deserving of consideration.

106. If the proposals we have put forward for the admission of all cases as either Voluntary or Temporary patients are adopted, very few senile patients will remain to be dealt with by Reception Order, since the great majority will have been discharged or have died within two years of admission, or will have acquired Voluntary status; and the stigma of the Reception Order itself will have been largely removed by the suppression of the opprobrious terms associated with it.

107. We conclude, therefore, that no special legislation is needed to deal with the mental disorders of the aged, and that the problems we have discussed can be solved by practical measures within the framework of the general health services and of the comprehensive mental treatment legislation advocated here.

PART 2

MENTAL DEFICIENCY

108. Before outlining our proposals for changes in the law, it is necessary to state briefly what we consider to be the nature of mental deficiency and how this conception should influence legislative action.

109. Mental Deficiency is not to be regarded as a disease or group of diseases in the medical sense, but as a term covering a large number of individuals whose common feature is a failure to acquire the ability to meet the minimum requirements of the society in which they live. They may indeed be suffering from the effects of physical disease or injury, maldevelopment before birth, brain injury at birth or later, abnormalities in the chemistry of the body, infections of the brain in childhood or adolescence, and so forth. Others, however, owe their disability to adverse environmental conditions in early life. And there are many who are not qualitatively different from normal individuals, but who happen to belong to the lowest group of a continuous range of mental giftedness extending over the whole population.

110. All these conditions are rightly regarded as a failure of the mind to develop, hence the present legal definition of mental defectiveness as "a condition of arrested or incomplete development of mind". For practical reasons, it is required that the condition shall have existed before the age of eighteen. As regards causation the definition is comprehensive, but not quite comprehensive enough; the defectiveness is required to have arisen from inherent causes or to have been induced by disease or injury, but defect arising from a psychological cause in early age has not been recognized.

111. This "condition of arrested or incomplete development of mind" may, however, be manifested in very varied ways. A usual manifestation is failure to develop what is com-

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monly known as intelligence—functions which can be measured by psychometric methods and assessed under such terms as "mental age" or "intelligence quotient"; but this is by no means invariable, and in other cases the undeveloped mind may be manifested chiefly by failure to attain normal control of the emotions or to achieve the qualities needed for normal social behaviour.

112. Disturbances of emotion and adaptation may also occur in conditions other than mental deficiency, and the diagnostic skill of the psychiatrist is required to differentiate between the developmental failures now under consideration, the adjustive disorder of the psychoneuroses, the deeper abnormality of gross mental disease, or psychosis, and the more indeterminate anomaly of the psychopath.

113. Mental deficiency legislation exists to meet the need of the afflicted individuals for special care and treatment, and also to some extent in the interests of prevention and of the protection of the community. This need arises out of the patient's inability to meet the minimum requirements of society, or in brief his social inadequacy. Social inadequacy is, therefore, the criterion for bringing into operation the special care measures provided by the law, and it is immaterial whether the inadequacy is associated with a lack of "intelligence" or with an emotional or adaptive defect.

114. That this was the intention of the Mental Deficiency Acts is shown by the definitions of the four classes of defectives recognized by the Acts, which are framed entirely in terms of social capacity and social behaviour. But, possibly because the study and measurement of "intelligence" came earlier in date than that of personality and social maturity, there has been a tendency in practice to require, as evidence of mental defect, that the patient should fall below a certain arbitrary level on one of the recognized "intelligence test scales".

115. We recommend that in future legislation the wider conception of mental defect should be recognized, and that it should be expressly stated that the condition of arrested or incomplete development of mind shall be judged by the patient's social inadequacy.

Terminology

116. It is generally agreed that the present terms are disturbing to the public and especially to the relatives of the patients. The adjective "mental" is so closely associated in the public mind with severe mental disorder as to be unacceptable in any other sense; press articles and news items constantly confuse mental disorder and deficiency. We suggest that in the new Act the words at present used as the definition should become the title itself, i.e. the term "person suffering from incomplete or arrested development of mind" should be used instead of "mentally defective person". This might be abbreviated to "undeveloped" or "under-developed person", "socially inadequate person", or "patient", as the sense may require.

Age Limit

117. The present Act requires that there should be evidence that the defect has arisen before the age of 18. We recommend that an age limit should be retained, but there might be advantage in raising it to 21. The justification for this is that social inadequacy may not become evident until the individual is faced with the need for adaptation to adult conditions, such as employment or national service.

Classes of Defect

118. We are of the opinion that there is no need to retain the present legal distinctions and definitions of the grades of idiot, imbecile, feeble-minded and moral defective, and these terms should not appear in documents which may be seen by the patient or his relatives, though clinically the first three terms may still be found of use to describe briefly the degree of defect.

119. We suggest instead that the following definitions should be used for the term "socially inadequate".

"The expression 'socially inadequate' shall be deemed to include such conditions of arrested or incomplete development as render persons in whom they exist:

(a) incapable of guarding themselves against common physical dangers;
(b) incapable of managing themselves or their affairs or, being children, of being taught to do so.
(c) unable to conform to the generally accepted standards of social behaviour or, being children, of being taught to do so;
(d) incapable, in the case of children, of benefiting from the education provided in schools under the Education Acts or unsuitable for attendance at such schools."

120. For the purpose of deciding on a patient's eligibility to be admitted to hospital without Judicial Order, as explained below, we would introduce a further distinction between patients who are incapable of understanding what is involved in their admission and those not so incapable.

121. We also recommend the abolition of the list of special circumstances rendering a defective "subject to be dealt with"; as will be seen later we are recommending that where a Judicial Order is applied for it should be on the general grounds of a need for care and treatment.

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Aims of Care and Treatment

122. Although many defectives need permanent care, there are cases in which improvement may be brought about by medical treatment, and these may be expected to become more numerous with advances in medical knowledge. Many other patients of the higher grade can, by careful training, be enabled to resume their place in the community. We think that this medical and curative aspect should be emphasized rather than that of legal control, and we therefore recommend that the term "care and treatment" should be used instead of "care, supervision and control", and that the places where care is provided should be called hospitals instead of institutions.

Methods of Admission to Hospital

123. There should be provision for four classes of admission to care and treatment.

(a) To hospital for temporary treatment.
(b) To hospital without Judicial Order, either voluntarily or by "placing".
(c) To emergency accommodation pending the making of an Order.
(d) To hospital or guardianship under Judicial Order.

(a) *Temporary Treatment*

124. By this is meant admission to hospital for a limited period for purposes of observation and diagnosis, or for a short course of treatment, or on grounds of domestic urgency. Admission for the last two reasons has already been sanctioned by the Ministry of Health (Circular 5/52) and the procedure has proved most valuable, enabling many patients to be cared for at home, but admitted to hospital during physical illness, or while the mother takes a much-needed holiday. We recommend that such admissions should be for not more than three months at a time, and should be without formality and subject only to acceptance by the Medical Officer. Similar notification to the Board of Control as is now used should be required of the Medical Officer.

(b) *Admission without Order*

125. We believe that the principle of voluntary admission should be applied in the field of mental deficiency in a similar way to that provided for mental disorder, and we recommend accordingly that the Medical Officer of a hospital for defectives should be empowered to accept:

(i) At the patient's own request, a patient over the age of 16 years.
(ii) At the request of the parent or guardian, or of the Local Authority where there is no parent or guardian, a patient under 16 years of age.
(iii) At the request of the parent or guardian, or of the Local Authority where there is no parent or guardian, a patient over the age of 16 who is incapable of forming an understanding of what is involved in his admission.

126. A request under (ii) should be supported by one recommendation, made by any medical practitioner. For admissions under (iii), two medical recommendations should be required, of which one should be made by a medical practitioner specially qualified and experienced in mental deficiency and approved for the purpose by the Board of Control. It should be permissible for not more than one of the recommendations to be made by a member of the staff of the receiving hospital.

127. Each case admitted under the provisions of this section should be the subject of special psychiatric examination, and a formal report should be sent to the Board of Control not later than six months after admission and thereafter at prescribed intervals.

128. *Leave of absence*. The Medical Officer should have power to grant to patients under this section leave of absence for any period.

129. *Discharge and Withdrawal*. The Medical Officer should have the power to discharge any patient under this section. A voluntary patient under (i) should have the right to discharge himself; and the parent, guardian or Local Authority, as the case may be, should be empowered to withdraw a patient admitted under (ii) or (iii); in all cases on giving 72 hours' notice. A patient admitted under (ii) should be automatically discharged on reaching the age of 16; he could, however, be re-admitted under paragraph (i) or (iii) or under Judicial Order, whichever is appropriate.

(c) *Emergency Admissions*

130. The present procedure by which defectives may in emergency be admitted to a "place of safety" is satisfactory. There is, however, at present no stated limit to the time during which the patient may be retained in the "place of safety", and we suggest that a period of not more than two months should be allowed. The procedure should only be used with a view to placing the patient under Order, and temporary admissions needed for other reasons should be effected under the procedure recommended in Section (a) above.

(d) *Admissions under Judicial Order*

131. We recommend the retention of the Judicial Order for cases in which the patient is ineligible for admission under Section (b) or in which there has been failure to use the facilities of Section (b) or they have ceased to be used, or where it is desired to place the patient under guardianship. In all such cases it should be necessary to show clearly that admission to in-patient care, or to guardianship, is essential in the interests of the patient or for the protection of the public.

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132. Patients ineligible for admission under Section (b) will be those over the age of 16 who do not themselves request admission and who are capable of understanding what admission involves. Cases where there has been failure to use the facilities of Section (b) will be those where the parent or guardian fails or refuses to apply for the patient's admission although this is urgently necessary. Cases where the facilities of Section (b) have ceased to be used will be those where a patient admitted without order discharges himself, or is withdrawn by the parent or guardian, though still in need of care and treatment.

133. We believe that in all such cases the intervention of a Justice is essential for the reassurance of the relatives and the public, the protection of the medical practitioner and officials concerned, and the public assertion of the principle of the liberty of the subject. Especially when dealing with the higher grades of defectives, safeguards are needed beyond what is required in the field of mental disorder, because the nature of the condition is not always apparent to the relatives or the public; moreover, because of the need for consistent care and stable environment it would be impracticable to concede to the relatives of defective patients under Order (who by definition have failed to provide the necessary care), the same powers of discharge as may be allowed in the case of mental illness.

134. In addition to the above, the Judicial Order will be needed for cases in which a Court recommends that a petition for such an order should be presented. The provisions of the present Sections 8 and 9 of the Mental Deficiency Act, 1913, by which orders may be made by the Court itself, and in certain circumstances by the Home Secretary, should be retained.

PROCEDURE FOR JUDICIAL ORDER

135. The petition should in all cases be presented by the Local Authority, and should include a statement of the reasons why action is being taken, and of the evidence showing that admission is essential for the welfare of the patient or the protection of the public.

136. There should be two medical certificates, and one of them should be given by a specially qualified practitioner. This should apply also to the medical evidence required under Section 8.

137. The present rules as to time limit should continue.

138. Since the use of the Judicial Order will be limited to cases where there is a proved need for admission, it should not be necessary to obtain the consent of the parents or guardian; but they should have the right to be present at the proceedings and to be heard or to be represented.

139. In the case of patients who have discharged themselves or have been withdrawn from hospital, it is inadvisable that proceedings should take place within the hospital. Such patients should normally be allowed to leave, and the case notified to the Local Authority, who will take action if this appears necessary. But where the Medical Officer is of the opinion that the patient's departure from hospital would involve danger to himself or others, he should have power to issue a certificate barring the discharge and to retain the patient in hospital until a petition can be presented and heard; in such cases the hearing might take place within the hospital.

ORDERS BY THE HOME SECRETARY

140. These apply to patients found to be defective while undergoing penal detention. We do not support the suggestion sometimes made that such Orders should cease to operate when the Court's sentence has reached its end. It has been found by experience, however, that the present limitations placed upon the granting of parole to patients admitted under such Orders hampers their proper treatment, and we recommend that the rules be reconsidered.

PROVISIONS REGARDING PATIENTS UNDER CARE

PERIODICAL RECONSIDERATION

141. The present system of periodical reconsideration is in our opinion necessary, and for the reasons previously stated we consider the Justices' function is an essential part of the procedure. We recommend, however, that it should apply only to cases under Order.

142. The change from a yearly to a five yearly period between successive reconsiderations is, we think, too abrupt, and we recommend that the prescribed periods should be 1, 1, 3 and 5 years, and then every 5 years.

143. No value is seen in the special reconsideration at the age of 21, and we recommend its abolition.

144. At each reconsideration, the parents or guardian should have a right to attend, and they should be notified beforehand of the intended visitation. They should have the right to obtain an independent psychiatric opinion on these occasions on giving due notice. The Regulations should provide that such an independent examination should be held at a suitable time before the patient is seen by the Visitors. The examination should be held at the hospital unless the Medical Officer agrees otherwise, and he should have the right to be present. The external examiner should have full access to the clinical records and other documents in the case.

LEAVE AND LICENCE

145. We recommend that the Medical Officer should have power to grant temporary leave of absence to any patient up to a maximum of six weeks. For any longer period, absence

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should be under licence, and this should continue to be granted by the Medical Officer with the concurrence of two members of the Committee.

146. The purpose of granting licence is to provide the most suitable form of help for the individual patient. Its continuance should depend solely on the need for this form of help, and not on any arbitrary time-limit. In many cases, the full benefits of licence can only be received if the patient remains in direct contact with and guidance is given by the hospital which has been responsible for him from the beginning.

147. The clause in the "form of authority" restricting association with the opposite sex is not in our opinion appropriate if interpreted in any strict sense, since the intention of the licence is to train the patient to live a reasonable life in the community. It is in any case commonly disregarded. We recommend that it should be replaced by a clause in more general terms, restraining the patient from forming any undesirable associations.

Absence Without Leave

148. We recommend that patients absent without leave should be discharged automatically after remaining at large for six months. We suggest also that changes should be made in the procedure for retaking such patients on the same lines as those recommended for mental hospitals.

Discharge from Order

149. We recommend that the Board of Control's present power of discharge should continue. In addition, the Visiting Justices, at any of their visits, should have the power to order a patient's discharge on the advice of the Medical Officer.

150. Under the present Acts, a patient discharged from Order but still needing supervision can only receive this if he is "ascertained" as a new case by the Local Authority. We recommend that it should be made possible for a patient to be discharged directly to statutory supervision.

Transfer to Mental Hospital

151. Cases arise from time to time in which it is desirable to transfer a patient temporarily from a mental deficiency to a mental hospital for the purpose of some special treatment which can most conveniently be given there. We recommend that such a transfer, for a maximum period of three months, should be made possible, subject to the consent of the Medical Officer of the receiving hospital, without any formality beyond the granting of leave or licence to the patient.

152. Transfer of defective patients to mental hospitals for longer periods may be needed because of supervening mental illness. In such cases the ordinary procedure for admission to the mental hospital as a voluntary or temporary patient should be followed, but neither this nor any subsequent Reception Order should supersede an Order made under this part of the Act, and on discharge from the mental hospital the patient should, if the Order is still in force, be returned to the mental deficiency hospital or to licence from that hospital.

The Medical Officer

153. In the above recommendations, the term "medical officer" has been used throughout, as it is in the present Acts, to denote the medical practitioner to whom the statutory responsibilities and duties in connection with hospital care are confided. This is because there is no uniformity in the administration of places in which defectives are cared for, or in the kind of medical skill available to them. While the larger institutions are generally under the control of a Medical Superintendent and have a medical staff trained and experienced in psychiatry and in the particular field of mental deficiency, many defectives are cared for in small units under the control of lay persons or nurses, with medical attention given by a general practitioner. We recommend that in future all in-patient defectives should have skilled psychiatric supervision made available to them either by grouping small units with large ones under a Medical Superintendent, or where this is impracticable by arranging for periodic visitation of the unit by a psychiatrist of similar standing. In hospitals where there is a medical staff of sufficient status, the principle of delegation should apply, as recommended for mental hospitals.

Notification of Deaths to Coroners

154. Our recommendations under this heading in connection with mental hospitals apply equally to mental deficiency hospitals.

General Recommendations

Unified Responsibility for Care

155. The present division of responsibility between the Local and Hospital Authority for the same patient at different stages of his life has the same disadvantages for mental defectives as we have previously pointed out in connection with mental disorder. Every means should be devised to promote co-ordination and unity in the care of the patients.

156. In carrying out its duties under the Act the Local Authority should invariably make

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use of skilled psychiatric assistance. In particular the examination of suspected cases of mental defect should be made by a psychiatrist experienced in this field.

Community Care

157. An expansion of facilities is needed for community care, both of patients discharged or on licence from hospitals and of those not requiring hospital care.

158. Clubs under psychiatric supervision and with suitable recreational facilities should be established; they might be combined with out-patient clinics, and some might develop along the lines of "day hospitals".

159. Residential Hostels are needed for patients on licence and at work, as well as for uncertified defectives of various ages who cannot live with relatives and cannot make suitable arrangements for themselves. Some of these hostels could be provided jointly by the Local and Hospital Authorities. Occupation centres and special workshops should be further developed.

Financial Support

160. In discussing the granting of leave to patients in mental hospitals we drew attention to the need for co-operation between the National Assistance Board and the hospital, and recommended that the Board should have regard to the medical and social requirements of each case, on the advice of the hospital. We believe that the same principles apply to the mentally defective. Financial support of the patient in the community should not be divorced from the general treatment of which it must be a part; it should not, therefore, be left to the unguided action of the Board operating a fixed scale of assistance.

161. In the case of patients under supervision by the Local Authority, we recommend that the Authority itself should have power to give financial support.

Civil Responsibilities of Defectives

162. There appears to be a need for clarification of the law of contract and tort in regard to mental defectives, as well as of their civil status, and we recommend that these matters should be examined with a view to a re-statement or revision of the law.

163. As regards marriage, the Association has stated its views in evidence given before the Royal Commission on Marriage and Divorce. It asked for clarification of the provisions of Sections 8 (1) (b) of the Matrimonial Causes Act, and suggested that the Section should be taken to apply only to defectives "ascertained" or "certified" under the Act. If our present proposals are adopted, a suitable alteration will be needed in this interpretation.

Part 3

PSYCHOPATHIC STATES

164. There remains to be considered a group of persons suffering from forms of mental abnormality which may be difficult to classify or to relate to the more definite mental illnesses or defects, but which nevertheless affect their behaviour adversely so as to render them delinquent or otherwise anti-social. Such conditions are loosely called "Psychopathic".

165. Behaviour of this kind may, in many cases, be a manifestation of mental defect, as explained previously; it may result from one of the grosser mental illnesses in an early or not fully developed stage, such as schizophrenia or the manic-depressive psychosis; or it may be related to a psychoneurosis such as hysteria and be associated with other neurotic symptoms. Similar behaviour may also follow organic disease or injury of the brain.

166. But when these well-recognized groups have been eliminated there remain a number of patients whose daily behaviour shows a want of social responsibility and of consideration for others, of prudence and foresight and of ability to act in their own best interests. Their persistent anti-social mode of conduct may include inefficiency and lack of interest in any form of occupation; pathological lying, swindling and slandering; alcoholism and drug addiction; sexual offences, and violent actions with little motivation and an entire absence of self-restraint, which may go as far as homicide. Punishment or the threat of punishment influences their behaviour only momentarily, and its more lasting effect is to intensify their vindictiveness and anti-social attitude.

Difficulties in medical diagnosis should not, however, stand in the way of practical measures, and it is clear that what is needed is the provision of facilities for treatment on a voluntary basis for those who may be benefited and are willing; and for the compulsory segregation, with treatment where possible, of severe cases, where this is needed for the protection of others.

167. Logically, it might be contended that all such cases are instances of either mental defect or disorder, according to whether the condition arose during development or was acquired later; and therefore, if there is severe disturbance of behaviour it should be possible to deal with the patient under the compulsory provisions applicable to mental disorder or mental defect.

168. Undoubtedly, a number of such cases are so dealt with every year. But the "intellectual" bias in mental deficiency practice has generally excluded patients with emotional

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and adaptive defects, even when they were true failures of development; and in the practice of mental disorder, a similar tradition has identified "certifiable insanity" too closely with loss of intellect or the presence of delusions. Consequently, psychopathic patients, though their minds are far from sound, are commonly said to be "not certifiable as of unsound mind".

169. There is, of course, no legal obstacle to the admission of such persons as voluntary patients to mental hospitals, or without formality to neurosis centres or psychiatric wards of general hospitals. The Industrial Unit at Belmont Hospital is an outstanding example of a centre where treatment is given on a voluntary basis, using new and original methods which have been devised in the Unit itself. The difficulty is that such centres are not available in sufficient numbers or variety, and the mental hospital is suitable for only a limited proportion of patients of this kind.

170. Care and treatment under compulsory conditions can be and are in a number of cases provided by means of a prison sentence, if an offence has been committed which is so punishable. Following the East-Hubert report of 1939, psychological treatment is being given within the prison to a limited extent, and there will be further facilities when the proposed special prison for such cases is opened. Treatment under prison conditions is not, however, always appropriate, and its duration is always limited by the length of the sentence.

171. A measure of compulsion of a different kind has been introduced by Section 4 of the Criminal Justice Act, 1948. It is noteworthy that this has been done without any attempt at a definition or even a description of the mental states to which it applies. It is sufficient that "the offender's mental condition, though requiring and susceptible to treatment, is not such as to justify certification". It would seem that a condition "susceptible to treatment" must be an abnormal one; and in practice it is the abnormality which is established by the medical report, and susceptibility to treatment is taken for granted, even in cases in which the prognosis is very poor.

172. The Court's powers under Section 4 are limited to making it a condition of probation that the offender shall submit to treatment for a maximum period of 12 months, in a mental hospital or elsewhere.

173. We suggest that in cases where a more prolonged detention is necessary for the protection of others, compulsion might best be applied by an extension of the Court's powers. That is to say that the Court, being satisfied that the offender's mental condition, though requiring and susceptible to treatment, is not such as to justify his being dealt with as a case of mental disorder or defect, and being also of opinion that the offender needs care and supervision for the protection of others, might make an order, similar to that under Section 24 of the Act (now superseded by Section 30 of the Magistrate's Courts Act, 1952) requiring his admission to an appropriate institution. The order might be valid for a limited time, and might be renewable by a procedure introducing reconsideration by visiting Justices or by a special Visiting Board.

174. In some cases it may be desirable to use the method of Section 4 first, and if the patient at the end of the year has not responded to treatment, the proposed new powers could be invoked.

175. If, however, it is felt that such extended powers could not safely be given to a Court without the introduction of a more precise definition of the class of case to whom they are to be applied, we would recommend a definition based on that suggested by a committee of the National Association for Mental Health, modified to accord with the terms used in our other recommendations:

"That the offender is a psychopathic offender; that is to say, a person who though not suffering from mental illness or from arrested or incomplete development of mind, is yet mentally abnormal in that he has shown persistent disturbance of emotion and will, resulting in irresponsible behaviour and delinquency or cruelty, and is incapable of modifying this behaviour in the light of experience."

176. Given these extended powers for action by the Courts, and assuming that suitable institutions can be provided for the reception of both Court cases and voluntary patients, as recommended below, it should be possible to bring under care and treatment the majority of persons needing such care. There will remain, however, a group of persons unprovided for because their anti-social behaviour is of a kind that does not lend itself easily to prosecution before the Courts. The psychopath's behaviour may consist of a constant repetition of acts of cruelty, each too trivial to be a punishable offence, but by their accumulation "causing danger to the bodily or mental health of others or giving rise to a reasonable apprehension of such danger".

177. This kind of conduct is familiar to the Matrimonial Courts, and spouses subject to it are able to obtain relief by divorce proceedings, but such relief is not available to other members of the psychopath's family, or to members of the public who may be affected by his behaviour.

178. It should be noted that when such conduct occurs in association with the "traditional" signs of mental illness mentioned above, it is always held to provide additional justification for compulsory treatment; in fact it has at some periods been argued that compulsion is only legitimate in the presence of such conduct.

179. We think, therefore, that there is a case for some procedure by which such persons can be brought under care. But because such a measure, though not involving any new

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principle, does mean an extension of present custom and practice, safeguards of an exceptional nature should be provided.

180. We suggest that the procedure should be by way of a special form of petition to a Court, to be presented by the patient's relatives. This should be accompanied by a full statement of the facts, and supported by two medical recommendations, given by the patient's own general practitioner (where possible) and by a psychiatric specialist. If the evidence seems strong enough, the next step would be for the Court to order an examination by an independent specialist. The Court order would sanction the patient's admission to an institution as described below.

Institutional Care

181. Legal provision for care and treatment is, however, of no avail unless suitable institutions are provided where this can be given. To some extent existing hospitals can be used, but it will be necessary to establish special institutions of various types.

182. A certain number of psychopathic patients may be appropriately treated in mental deficiency hospitals, in the company of high-grade patients, from whom they do not differ very greatly.

183. Others may be suitable for admission to mental hospitals (as happens now under Section 4), especially if the hospital has facilities for active psychological treatment and the patient appears likely to benefit from this; or to special hospitals and neurosis centres.

184. New institutions which should be established include:

One or more on the lines of a colony, with a regime under lay disciplinary control and psychiatric advice and treatment provided by a skilled medical staff.

One or more of the Belmont Unit type.

Some on purely medical lines for the treatment of alcoholism and drug addiction.

185. Because variety and suitability are more important than geographical location we recommend that such institutions should be established on a national or inter-regional basis. Further we attach great importance to the careful allocation of the patient to the institution or hospital for which he is most suitable. For this reason we recommend that this allocation should be done, after the Court's order has been made, by a psychiatric authority well acquainted with the facilities and resources available, and able to take into account the needs of the individual patient in relation to these, such as the Regional Psychiatrist. There should be considerable elasticity in the arrangements and patients should be easily transferable from one type of institution to another. Suitable institutions should be open to voluntary patients without formality, as well as to those under Court Order.

186. For the same reason we recommend that, if these proposals or any of them are adopted, they should not be brought into force until sufficient special accommodation has been provided to enable a successful start to be made.

Miscellaneous Recommendations

Proceedings in Juvenile Court

187. We wish to draw the Commission's attention to what we feel is an undesirable provision of the Children Act, 1948, whereby unnecessary distress and actual harm may be inflicted on certain mental patients.

188. Section 2 of the Act provides that a local authority may assume the rights and powers of a parent, if the latter suffers from some permanent disability rendering him or her incapable of caring for the child. If the parent objects, the local authority may complain to a Juvenile Court, which may overrule the objection; the Court, however, must satisfy itself that the parent is unfit to have the care of the child by reason of unsoundness of mind or mental deficiency.

189. It will thus be seen that in such cases the issue of the patient's state of mind must be argued in court, evidence heard for both sides, and medical witnesses subpoena'ed. Cases of this kind arise where a mother has left hospital not fully recovered, and it is clear that the child ought to remain in the care of others for the time being, though the patient herself cannot realize this. In such cases the medical evidence has to be given by the doctor who has treated the patient in hospital and may still be treating her as an out-patient.

190. The Association has always opposed anything of the nature of a public trial of insanity except as part of criminal proceedings, and this view has been upheld by successive Royal Commissions. We suggest that the Act should be amended so that any appeal against the local authority's resolution should be a matter for consideration in private by a Judicial Authority.

Patients' Allowances and Rewards

191. We have already referred to two aspects of patients' finances, namely additional measures for the protection of patients' property (Para. 81) and the maintenance of patients on leave (Para. 76) or on licence (Para. 160).

192. We wish to bring to the Commission's notice the inconsistencies and anomalies which exist in connection with the payment to patients in hospitals of benefits, allowances and rewards from different sources. These anomalies arise from the application of various

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Acts and Regulations, not specially designed with a view to use in mental or mental deficiency hospitals, and therefore framed without regard to their effects when so used.

193. Many short-stay patients receive benefits which are adequate or even excessive for their needs, but the good effect is often spoilt by delay in the commencement of payments.

194. National Insurance Officers do not always co-operate sufficiently with the hospitals in deciding how the benefits to which the patient is entitled shall reach him, and often money is paid out to relatives to whom too much latitude is given; this applies also to money payable from other official sources.

195. Many long-stay patients are sufficiently "in benefit" to obtain a liberal pocket-money allowance for many years; others not so entitled are dependent on allowances made by Hospital Management Committees, and for those very little can be spared out of the Committees' limited budgets. For this same reason rewards given to working patients are too low, especially in relation to sick benefits, to act as incentives to therapeutic occupation.

196. Married women in whose case maintenance orders have been made before their admission continue to receive this maintenance while in hospital; and in the case of women divorced while in hospital, the Court generally orders the continued payment of pocket-money. On the other hand, other married women have no right to any allowance by their husbands so long as they are receiving "free" maintenance in hospital.

197. We recommend that these matters should receive further consideration, perhaps by an Inter-Departmental Committee, so that these anomalies and hardships may be removed.

The Board of Control

198. We have throughout referred to the Central Authority as "The Board of Control". We believe that the continued existence of the Board, substantially in its present form, is in the interests of the patients, of the hospitals and of the public.

199. We recommend that the Board should be maintained in a position of relative independence, so that its reports may have the value attaching to an impartial inspectorate. Since Society finds it necessary to detain compulsorily a large number of people whom it has no wish to punish, but only to care for and treat, it follows that Society has a moral obligation to see that those so detained are cared for under conditions that satisfy the public conscience. For this reason alone, the hospitals for mental disorder and mental defect need to be inspected and reported on by persons empowered to report and criticize solely from this point of view, uninfluenced by any consideration of departmental policy.

200. We believe also that the scrutiny by the Commissioners of admission documents and continuation certificates is an essential part of mental treatment legislation, since in no other way can a uniform standard be maintained by which the justification for detention can be measured.

201. We recommend that the number of Commissioners should be sufficient to allow of personal visitation of all cases which seem to call for inquiry, and also to allow the visiting Commissioners ample time for their inspections and for preparing their reports. The Commissioners should be persons of such professional standing as to command the confidence of the Hospital Authorities and Staff.

202. For the reassurance and education of the public we believe it necessary that the fullest possible publicity should be given to the work of the mental health services and to the condition and needs of the hospitals. We recommend, therefore, that the Commissioners' collected reports should be published annually, as was done up to 1938, and that there should also be a full Annual Report on the state of the mental health services on a scale commensurate with their importance.

SUMMARY OF MAIN RECOMMENDATIONS

Part 1. Mental Disorder

1. Adult voluntary patients should be admitted without formality; alternatively, the written application should be in the simplest possible form. (Paras. 23-26.)

2. It should no longer be stated that voluntary admission is "for mental illness". (Para. 27a.)

3. Voluntary patients should have the right to depart without giving previous notice. If notice is still required, the period should continue to be 72 hours. (Paras. 28 and 58.)

4. Voluntary patients who become incapable of expressing themselves as willing or unwilling should be allowed to retain their voluntary status. (Para. 29.)

5. All initial admissions other than voluntary should be in the status of Temporary Patient, without a Judicial Order; two medical recommendations to be required, of which one from a practitioner experienced in psychiatry; the period of validity to be one year, extendable to two; the patient to have the right to interview a magistrate after admission. (Paras. 30-41.)

6. Judicial Orders should be necessary after completion of one year (or two years as the case may be) of Temporary treatment; two medical recommendations should be required. (Paras. 42-43.)

7. Changes in terminology should be made in connection with the Judicial Order, and in particular the terms "certification" and "certified patient" should no longer be used. (Para. 44.)

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8. Special reports at statutory intervals should be required for patients under Order; changes are recommended in their wording. (Para. 45.)

9. Procedure for emergency admissions should be simplified; it is recommended that either a Mental Welfare Officer, or a relative (with medical support) should be able to make a three-day order (extendable to 21 days) for admission to an observation unit or designated mental hospital. (Paras. 46-49.)

10. Recommendations are made covering the designation of hospitals for this purpose. (Para. 50.)

11. Medical Superintendents of mental hospitals should have discretion to decide on priority of admissions of all categories. (Para. 52.)

12. Local Authorities should take a broad view of the functions and duties of Mental Welfare Officers, who should form an essential part of a comprehensive mental health service. (Paras. 53-55.)

13. The legal provisions for the protection of persons exercising duties under the Act should be extended to all persons giving professional advice or information. (Para. 57.)

14. The Medical Superintendent should retain the power to discharge a voluntary patient. (Para. 58.)

15. In the case of voluntary patients retained in hospital under Recommendation 4, the appropriate relative should have a power of discharge. (Para. 60.)

16. The Medical Superintendent should be empowered to discharge a Temporary or Reception Order patient; the present right of discharge possessed by any three members of the Committee to be retained. (Paras. 61-63.)

17. The "appropriate relative's" power of discharge should be restricted by an alteration in the wording of the barring certificate. (Paras. 64-65.)

18. The definition of the "appropriate relative" should be revised. (Para. 66.)

19. Local Authorities should have a duty to admit to Part III Accommodation patients being discharged from mental hospitals who would otherwise be homeless. (Para. 68.)

20. The provisions regarding leave of absence should be made uniform for all hospitals and all categories of patients. The Medical Superintendent should be empowered to grant leave for specified renewable periods to patients of all categories. (Paras. 69-72.)

21. It should be permissible to grant leave from one mental hospital for the purpose of special treatment at another mental hospital, without transfer formalities. (Para. 74.)

22. Financial provision for patients on leave should be made by the Hospital Management Committee, or where appropriate by the National Assistance Board, who should be required to have regard to the recommendations of the hospital authorities. (Para. 76.)

23. The "recapture" period for a patient absent without leave should be 28 days. (Para. 77.)

24. Recommendations are made for more convenient arrangements in connection with the retaking of patients absent without leave. (Paras. 78-79.)

25. Legal provision should be made for the easy transfer of patients between England and Wales and other parts of the British Isles. (Para. 80.)

26. A simple and rapid interim procedure should be devised for the protection, immediately after admission to hospital, of patients' most urgent financial affairs. (Para. 81.)

27. Routine notification of deaths to the Coroner should be abolished. (Paras. 82 and 154.)

28. The principle of "medical authority" in mental hospitals should continue to be recognized. (Para. 83.)

29. Statutory medical powers and duties should continue to be entrusted to the Medical Superintendent, who should, however, be empowered to delegate them to other members of the hospital staff. (Paras. 84-85.)

30. Licensed houses and approved nursing homes should be amalgamated under a single designation, and freed from the restrictions imposed by the Lunacy Act of 1890. (Paras. 86-88.)

31. The admission of "Broadmoor" patients to mental hospitals should be subject to prior consultation with the Medical Superintendent. (Paras. 89-91.)

32. Patients at Broadmoor whose sentence has expired should not be transferred to ordinary mental hospitals unless suitable in the opinion of the Medical Superintendent of Broadmoor. (Para. 92.)

33. "Broadmoor" patients should retain a right of remission of sentence for good conduct. (Para. 93.)

34. The term "Broadmoor patient" should be replaced by that of "Home Office patient". (Para. 94.)

35. It should be made permissible to transfer a homicidal or potentially homicidal patient from a mental hospital to Broadmoor, or some analogous institution, without indictment or trial. (Paras. 95-97.)

36. The recommendations of the Association's Geriatric Committee are brought to the notice of the Commission. In general, no special legislation is recommended in relation to mental disorder in the aged. (Paras. 98-107.)

PART 2. MENTAL DEFICIENCY

37. Mental deficiency should be conceived as a condition of arrested or incomplete development of mind as judged by the patient's social inadequacy. (Paras. 108-115.)

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38. The terms "mental deficiency" and "mental defective" should not be used in legislation; other terms are suggested. (Para. 116.)

39. The age before which the Law requires the defect to have existed should be raised from 18 to 21. (Para. 117.)

40. The present legal distinctions between grades of defect should be abolished, as also the special circumstances rendering defectives "liable to be dealt with". (Paras. 118-121.)

41. Changes in wording are suggested to emphasize the medical and curative aim of the legislation. (Para. 122.)

42. Temporary admission for observation, short treatment, etc., should be permitted for up to three months, without formality. (Para. 124.)

43. There should be provision for the admission without order of certain categories of patients at their own request or at the request of their parents or guardian. (Paras. 125-126.)

44. Special reports should be required in respect of such patients. (Para. 127.)

45. The Medical Officer should be empowered to grant leave of absence to such patients. (Para. 128.)

46. Patients admitted without order should be dischargeable by the Medical Officer, at their own request, or at the request of a parent or guardian, as may be appropriate. (Para. 129.)

47. A "place of safety" procedure should be used for emergency admissions when it is intended to apply for a Judicial Order within two months. (Para. 130.)

48. Admission under Judicial Order should apply to patients of categories not eligible for admission without order, or in cases of proved necessity where there has been failure to use the procedure of Recommendation 43. (Paras. 131-134.)

49. Recommendations are made in regard to the procedure for obtaining a Judicial Order. (Paras. 135-138.)

50. Recommendations are made in regard to patients under Recommendation 43 who discharge themselves or are withdrawn from the hospital. (Para. 139.)

51. Periodical reconsideration by visiting Justices should apply to patients under order, but special reconsideration at the age of 21 is unnecessary. Recommendations are made in regard to procedure. (Paras. 141-144.)

52. The Medical Officer should have power to grant temporary leave of absence to patients under Order; licence for any longer period should be granted by him with the concurrence of two members of the Committee. (Paras. 145-146.)

53. Recommendations are made for an alteration in the "form of authority" used when granting licence. (Para. 147.)

54. Patients absent without leave should be discharged automatically at the end of six months. (Para. 148.)

55. The Board of Control, and the Visiting Justices, should have powers of discharge. (Para. 149.)

56. It should be possible to discharge patients direct to statutory supervision. (Para. 150.)

57. It should be possible to send patients, on leave, to a mental hospital, for the purpose of special treatment, without formality. (Paras. 151-152.)

58. All mental deficiency units should either be brought under the control of a Medical Superintendent or, where this is impracticable, should be visited by a psychiatrist of similar standing. (Para. 153.)

59. The Local Authority should invariably make use of skilled psychiatric assistance. (Para. 156.)

60. Community care should be developed, especially by the provision of clubs and hostels. (Paras. 157-159.)

61. Arrangements for financial support should be on similar lines to those recommended for mental disorder. (Para. 160.)

62. The law of contract and tort in regard to mental defectives should be clarified. (Paras. 162-163.)

Part 3. Psychopathic States

63. The powers of Courts under the Criminal Justice and Magistrates' Courts Acts should be extended to enable psychopathic offenders to be placed under care and treatment. A definition of "psychopathic offender" is suggested. (Paras. 164-175.)

64. There should be provision, subject to special safeguards, for dealing with psychopathic persons who cannot be charged with any particular offence, but whose behaviour is such that they require care and treatment for the protection of others. (Paras. 176-180.)

65. Although existing institutions can be used for some psychopathic patients, special institutions of various kinds are required. (Paras. 181-184.)

66. The allocation of patients to the appropriate institution should be made by the Regional Psychiatrist. (Para. 185.)

67. Legislation under this Part should not come into force until sufficient special accommodation has been provided. (Para. 186.)

Other Recommendations

68. Amendments are suggested to Section 2 of the Children Act, 1948. (Paras. 187-190.)

69. There should be a full consideration of matters relating to patients' monetary benefits, allowances, rewards, etc., with a view to remedying existing anomalies. (Paras. 191-197.)

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70. The Board of Control should be maintained in a position of relative independence; its duties of inspection and scrutiny of documents should continue; and its reports should be published in full, together with an adequate Annual Report on the state of the Mental Health Services. (Paras. 198-202.)

APPENDIX

REPORT OF GERIATRIC COMMITTEE, 1951

(1) Terms of Reference

To examine the problem of the elderly and aged patient in mental hospitals and to make recommendations for their more suitable accommodation and treatment.

(2) Nature and Extent of Problem

The Committee was primarily set up because the number of elderly and aged patients in mental hospitals is steadily increasing, resulting in severe over-crowding and, in many instances of other patients, more in need of active treatment, having to be denied admission.

The mental hospital impasse is only one facet of the problem, whose urgency and magnitude has forced itself on the notice of a general public which usually finds old age of little interest or popular appeal.

Between 1938 and 1948 the total population of England and Wales has increased by less than 2½ million (6·0 per cent.), while the 65 years and over population has gone up by over 1½ million (31·4 per cent.) and the percentage of people aged 65 and over in the total population has risen from 7·8 per cent. to 9·3 per cent. in men and from 9·5 per cent. to 12·2 per cent. in women. According to the Royal Commission on Population (1947) as many as 16 per cent. of the population are likely to be 65 years and over in 1977. We should expect this to be reflected in the number of old people in and awaiting admission to hospital, but the actual figures show a much steeper rise.

In the 10 year period 1938-48 the total mental hospital population fell by 3,135 patients, due, no doubt, to fewer available beds, whereas the number of patients aged 65 years and over increased during the same period by 7,674. This constitutes a fall of 10,809 patients under the age of 65 years, and underlines our observation that many younger patients have to be refused admission. The proportion of patients aged 65 years and over to the total mental hospital population rose from 14·8 per cent. to 19·1 per cent. in men and from 19·7 per cent. to 27·6 per cent. in women. Compared with the percentage figures of the elderly in the general population the mental hospital population has risen nearly three times as much in both men and women.

(3) Analysis of Causes of Rising Proportion of the Elderly in Mental Hospitals

The reasons for the alarming rise in the proportion of elderly patients to the total population in mental hospitals can be summarized as follows:

1. Increasing age of general population.
2. Loss of over 3,000 beds in mental hospitals.
3. Loss of beds for elderly patients in Public Assistance Institutions and other hospitals and institutions.
4. Social Factors:
   - (a) Housing shortage.
   - (b) Increased employment of women—no home help.
   - (c) Free accommodation in hospital under N.H.S.
   - (d) Decline of Family, Religious and Social obligations.

1. The increase in age in the general population has been shown to be reflected three-fold in the mental hospital population. This can, in part, be accounted for by the fact that (i) very few mental hospital patients are under the age of 16 years, and (ii) psychiatric illness tends to be more common in the elderly.

2. The reduction of over 3,000 mental hospital patients adds in some measure to the relative increase of elderly patients, because seniles are, for the most part, certified and must be accepted at the expense of uncertified patients mainly of younger age. This reduction of patients has been limited to 3,135 only by overcrowding, because the recognized bed space in mental hospitals was actually reduced by 7,639 beds at the end of 1949.

3. It has not been possible to obtain comprehensive figures for the loss of beds at Public Assistance Institutions, General Hospitals catering for elderly and senile patients, and accommodation under Part III of the National Assistance Act, but it is well known that many such beds, available before the war, are now closed owing to war damage, nursing shortage or economy, or are used for other purposes. The number of beds available for the elderly and chronic sick in pre-N.H.S. Act Local Authority Hospitals and Institutions had fallen in the South-East Metropolitan Region from 3,733 in 1938 to 2,422 in 1948.

Any estimate of how many of the elderly and aged now in mental hospitals are suitable for other accommodation cannot escape the personal bias of the assessor, but figures taken from two different sources leave no doubt that an appreciable proportion is suitable for these lost beds and is of the type accommodated in them before the war.

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4. The influence of social factors on the hospitalization of old people cannot be given in statistical form, but there is no doubt that many fewer families than before the war are now able or willing to care for their mentally or physically ailing old people in their homes. The main social factors are:

(a) *Lack of housing accommodation:* so many families are already over-crowded that it is impossible to give up a bedroom to a restless, talkative old person who has hitherto shared a room with another member of the family or has been living alone.

(b) *The increase in the number of women, and particularly of married women, now going out to work:* this is perhaps the most important social factor of all, for there are many senile patients in every mental hospital who could be discharged if there were a woman relative at home the greater part of the day.

(c) The stopping of all maintenance contributions under the N.H.S. Act, combined with the ever-rising cost of living, may well have made many families less willing to keep their aged relatives at home and more obdurate against having them back from a mental hospital. Unfortunately we cannot insist on their discharge unless they can be said to be "recovered".

(d) The decline in standards of family unity and of obligation to members of the family, together with the crumbling of the stigma of being admitted to a mental hospital have done much to produce the prevailing lack of social responsibility for elderly relatives. Waning religious influences and the modern trend of educational and political teaching are also important factors.

The foregoing analysis of some of the factors bearing on the overcrowding of mental hospitals with elderly patients has shown the position in a general way. A more detailed enquiry has been made in the case of admissions aged 65 and over to seven Borough or County mental hospitals, selected from rural and urban areas in both the north and south of the country.

For each hospital the figures for the male and female admissions were obtained, together with the deaths, discharges and numbers remaining after six weeks, six months, one year and two years. The figures were then examined both for the individual hospitals and collectively.

Admissions

These totalled 592, consisting of 199 males and 393 females, representing almost a twelfth of all admissions of patients aged 65 and over to former County and Borough mental hospitals during 1947. The highest number of admissions, 192, was to a hospital in a county with poor institutional accommodation, without female observation wards and with only 10 male observation beds for about 1½ million inhabitants. The lowest number of admissions, 25, was to a hospital in a large city with plentiful observation ward and chronic hospital facilities.

The Deaths

In seven hospitals for which the figures were examined the death rates varied between 5 per cent. and 25 per cent. of the admissions aged 65 and over in 6 weeks, 10 per cent. and 38 per cent. in 6 months, 12 per cent. and 42 per cent. in a year and 12 per cent. and 49 per cent. in two years after the patients entered hospital. From the figures it would seem that the hospitals in the series fall into two groups; three with about 5,500 beds in all, dealt with 392 of the admissions, the remaining 4 with over 7,000 beds had 200 admissions between them, suggesting that the latter four had more adequate observation ward or institutional facilities for the disposal of the patients. It was found that in 6 weeks, 6 months, 1 year and 2 years the first three hospitals had collective death rates of 22 per cent., 32·5 per cent., 38 per cent. and 44·5 per cent., whilst for the other four hospitals these were 8·5 per cent., 15·5 per cent., 18 per cent. and 26 per cent. It would, therefore, appear that there is a considerable difference in the number of deaths, if certain categories of patients are sorted out prior to admission.

Taking all the figures together, of the 592 admissions, 103 (17·4 per cent.) died in 6 weeks, 159 (26·9 per cent.) in 6 months, 186 (31·4 per cent.) in one year, and 225 (38 per cent.) within two years of their entry into hospital.

The Discharges

In the case of the discharges there was a much closer agreement between the first group of 3 hospitals, and the second of 4. The figures for discharges were for the group of 3 hospitals (392 admissions) and 4 hospitals (200 admissions), respectively, as follows: 37 (9·5 per cent.) and 15 (7·5 per cent.) after 6 weeks, 123 (31·5 per cent.) and 69 (34·5 per cent.) after 6 months, 147 (37·5 per cent.) and 85 (42·5 per cent.) in one year and 156 (40 per cent.) in two years after admission, though it seems throughout that those hospitals admitting a proportionately smaller number of elderly patients have been able to select those of better prognosis. The only exception in the figures is for the first 6 weeks, and the difference in numbers is consistent with a sampling error of no statistical significance.

For the whole of the hospitals collectively the discharge rate is 10·1 per cent. of the admissions during the first 6 weeks, but it rises rapidly to become 32·5 per cent. in the first 6 months, then comparatively slowly to 39·2 per cent. in a year and 42 per cent. in two years. The discharge rate is unexpectedly high if judged on the somewhat pessimistic standard so often assumed towards elderly admissions.

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(4) MEMORANDA ON WHICH RECOMMENDATIONS ARE BASED

1. We propose to formulate our recommendations on the framework of M. of H. Circulars H.M.C.(50)25 and (50)38 and the B.M.A. Special Committee Report on "The Care and Treatment of the Elderly and Infirm" (1947).

2. H.M.C.(50)38, entitled "Treatment of the Elderly Chronic Sick", suggests the principles on which a hospital geriatric service should be developed, and recognizes convalescent and long-stay annexes for the elderly sick no longer in need of active hospital treatment. It suggests that this accommodation might be in a separate part of a larger hospital, in special hospitals, or in annexes or homes linked with an acute hospital. Admission should be only by way of the acute hospitals, and the nursing staff should be linked with the acute hospital to allow for a rotation of staff and minimize the difficulty in obtaining nurses for chronic cases.

3. H.M.C.(50)25 on "The Care of the Aged Suffering from Mental Infirmity" contemplates the provision of:

(a) Short-stay psychiatric units.
(b) Long-stay annexes.

The short-stay psychiatric unit is envisaged as a small observation and investigation unit (not above 25 beds usually) developing as a part of the main geriatric department which it is hoped to form in all the larger general hospital centres. The short-term unit is considered mainly as a sorting house in which patients should not be kept more than 6 weeks. During this period some may have died, some may become fit to go home, a few may require mental hospital care, and the rest will be transferred to the long-stay annexes. (Some may be found suitable for accommodation under Part III of the National Assistance Act.)

In this circular the long-stay annexes are recommended for patients without marked behaviour disorder, and might be grouped either with Mental Hospitals or General Hospitals or Hospitals for the Chronic Sick. They should not in any case be a part of a mental hospital, and of course, the patients would be under no kind of Certification or Order. Medical care should be supervised by a Psychiatric Consultant.

Admission to the long-stay units would be from the short-stay unit, and perhaps also from mental hospitals, observation wards under Section 20 of the Lunacy Act, or direct from home. It is suggested that unused buildings on mental hospital estates, ex-public assistance institutions or larger houses might be used. The problem of obtaining nurses for the long-stay units is not touched upon in H.M.C.(50)25 although it is laid down that the staff should include mental nurses. The Report of the Mental Health Standing Advisory Committee (SAC(MH)(49)14), however, on which the H.M.C. is based, specifically recommended that the annexes should be grouped with mental hospitals and that the nursing staff should be derived from the linked mental hospital.

4. These recommendations are partly based on the B.M.A. Committee Report (referred to above) and agree with it in broad plan. The chief differences are: (a) The Ministry Circular applies its recommendations to patients aged 65 years and over, whereas the B.M.A. Report envisages a Geriatric Service for patients over 60 years of age. (b) The B.M.A. Committee proposes that the long-stay annexes should be in effect an extension of the geriatric department, and the patients should be admitted to them from no other source. The Ministry Circular allows admission of patients from other sources, and, in fact, the Mental Health Standing Advisory Committee (SAC(MH)(49)14) puts forward cogent arguments for admission in some instances from mental hospitals or direct from home.

(5) RECOMMENDATIONS OF THIS COMMITTEE

The recommendations of the B.M.A. Committee and the Ministry of Health are not immediately practicable because they involve (a) the erection of new buildings and/or the purchase, major adaptation or re-instatement of existing accommodation, and (b) the provision of more and more psychiatric nurses; these measures are prohibited at present by the economic and labour situation, and any prospect of early improvement in either looks far from hopeful. We shall therefore follow our long-term suggestions with a few more immediately practicable recommendations.

For the purposes of this investigation we have regarded geriatric patients as those aged 65 years or over, in part because 65 years is one of the Age-Group limits in the Board of Control Returns, and many of our figures have been obtained from this source. In practice there is no overriding reason to make a definite age limitation; some patients are suitable for a geriatric unit at 45, while others at 75 suffer from acute mental disorders essentially suitable for treatment in a mental hospital.

Long-Term Recommendations

We agree with the main conclusions of the B.M.A. Committee and the Ministry of Health, that short-stay and long-stay units should ultimately be provided.

Short-stay Units

We consider that short-stay units should be an integral part of a General Hospital and of its Geriatric Department. They should be administered by the Group Hospital Management Committee, visited by a Consultant Psychiatrist and nursed by the ordinary nursing staff of the General Hospital, with a doubly-trained Sister in Charge, and preferably one or more (according to size) mental-trained nurse in support.

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The unit should have small wards with adequate single-room accommodation. It should admit patients from the Main Hospital and from the Geriatric Department, and direct from their homes. Patients obviously requiring mental hospital care should be admitted, as at present, direct to an observation unit or mental hospital. The size of the unit will depend not only on the population of its catchment area, but on the proportion of patients aged 65 years or over suffering from recoverable mental disorder or for other reasons considered suitable for direct admission to a mental hospital.

Disturbed behaviour alone should not be a bar to admission, as many old people settle down within a few days with skilled medical and nursing care.

We have considered whether the suggested maximum period of 6 weeks is the most desirable period for patients to stay in those units and have come to the following conclusion:

If the function of the observation wards is to retain the patients for the period in which the greatest number of deaths will occur in the shortest time, probably six weeks or less is the time of choice. This would have the advantage of lowering the mortality rate amongst those admitted to mental hospitals or long-stay geriatric units. It would, however, have the disadvantage that most of the recoverable patients would have to be moved twice, which is never well tolerated in the elderly, and that they might have to go farther from home where less frequent visiting would be possible.

If, on the other hand, it is intended that most of the patients who are recoverable should also be discharged from the same units, then six weeks is too short a time for them to stay. For this purpose the optimum length of stay is between 6 weeks and 6 months, probably 3 or 4 months. A shorter period will save cost, while a longer period will lead to more discharges from the short-stay unit.

Long-stay Units

Administration and Staffing. We consider that the long-stay unit should be administered and nursed from a General Hospital Group, but should be under the clinical supervision of a Consultant Psychiatrist and preferably should have a doubly-trained sister in charge. Its junior nurses should be those of the General Hospital, with perhaps a greater proportion of Assistant Nurses or Ward Orderlies than in the acute wards. Student Nurses should serve in rotation a short training period in it. We do not consider it feasible or desirable to provide the nursing staff for these units from mental hospitals; the units should rather be attached to Teaching Hospitals (with which the main Geriatric Departments will presumably be linked) or to General Hospital Groups with flourishing nurse-training schools. Only by this means are sufficient nurses likely to be obtained to make the scheme practicable (see H.M.C.(50)38). In this same connection we strongly endorse the view expressed in SAC(MH)49(14) that the Standing Nursing Advisory Committee should be asked to consider the desirability of including geriatric instruction in nurse training.

Type of accommodation. There is much to be said in favour of fairly large units (200 beds and over):

1. They can provide better facilities for entertainment (cinema and shows), recreation and occupational therapy.

2. They are more economical.

3. Administration and provision of medical consultants, psychiatric social workers, physiotherapists, occupational therapists, etc., are likely to be facilitated. Homeliness can be ensured by having small dormitories and sitting-rooms and the unit should be divided into ambulant and sick divisions. An adequate number of single rooms should be provided for patients who are (a) talkative at night, or snore loudly or tend to be mildly restless, (b) suffering from mild infections, or (c) under observation for infectious diseases, e.g. tuberculosis.

Type of patient. Long-stay units should house elderly and senile patients suffering from mental deterioration of too great a degree for care in Part III N.A. Act accommodation. In the main they will be somewhat amnesic and confused, but not chronically noisy or disturbing to others. Occasional bouts of irritability, restlessness or talkativeness should not be a bar, nor should physical deterioration requiring confinement to bed.

Sources of admission. Patients should be admitted mainly from short-stay units, but also direct from their homes, from Mental Hospitals, and from other Hospitals and Institutions, including observation units with the approval of the Consultant Psychiatrist supervising the unit. We do not agree with the conclusions of the B.M.A. Committee that all patients *must* first go through the short-stay unit.

(6) Immediate Steps

Finally we make the following suggestions with a view to trying to alleviate the present burden, pending the implementing of more permanent schemes:

1. In order to reduce admissions of senile patients to hospitals and institutions:

(a) General Practitioners should be advised in the general care of the aged and in particular in the more practical use of sedatives, especially at night. This could be done by means of domiciliary visits, the appointment of more geriatric Medical Officers, Ministry of Health pamphlets, discussions at local B.M.A. Meetings, training of medical students in geriatrics, etc.

(b) More use should be made of psychiatric social workers and other welfare officers in persuading families to look after their own kin, in making arrangements

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for them to do so with the least possible disarrangement of their life, and in educating them in their responsibilities.

(c) More practical use should be made of Health Visitors, District Nurses and Home Helps. This could be done provided there is genuine co-operation between the local Authority and the Social Worker or Geriatric Medical Officer. Geriatric Medical Officers can be very helpful in preventing unnecessary admissions to mental hospitals, in educating General Practitioners in the management and disposal of senile patients and in saving many domiciliary visits and telephone consultations.

(d) Social Clubs for elderly people, sometimes called "Darby and Joan Clubs", have proved very successful in alleviating the loneliness and boredom, which so often precipitate mental breakdown in old people. The formation of these Clubs should be encouraged, and at least partly financed by Local Authorities. No doubt such voluntary bodies as the W.V.S. would give willing and valuable help in day-to-day administration, while the services of psychiatric social workers and occupational therapists would be of the greatest benefit.

2. Hospital or Institution wards closed for lack of nurses should be attached to Teaching Hospitals (or other hospitals which are well off for nurses) and re-opened for geriatric purposes, the nursing staff being provided by the linked hospital.

3. It should be heavily stressed that units for geriatric patients (whether physically or mentally affected) should be an integral part of the main hospital, and that it should be a part of the General Nurses' ordinary duties to be posted there in their turn. The need for this in regard to the General Hospital Geriatric Services has been recognized by the Ministry H.M.C.(50)38.

4. As suggested by the Standing Ministry of Health Advisory Committee, geriatric nursing should have an official place in a nurse's general training, and all student nurses should spend part of their training in a geriatric unit. This alone can upgrade the nursing of geriatric patients in a manner so greatly needed.

5. The maximum number of beds possible should be put up in old peoples' wards, even though it will cause overcrowding. The arguments against this are: (a) that it is a retrogressive step; (b) that the nurses would be overworked and would resign or become ill; (c) that the patients would be less comfortable and more prone to infections.

As to (a) we must be practical and temper our remedies to the gravity of the disease; (b) it is more economical both in nursing power and money to treat, say, 60 patients in two wards than the same number in three wards; and (c) we are forced to overcrowd in the mental hospitals, and senile patients have proved to be the least affected by this; they are less sensitive to infective illness, even feverish colds, and owing to their interests being so much narrower their conduct and comfort are minimally affected. This final recommendation must not be misinterpreted to suggest that we advocate a lower standard of care or comfort for the elderly. Companionship, comfort, kindliness and patient understanding are, if anything, more essential to the elderly, who have, so often, outlived most of their relatives and friends, than to young people, and should be the keynote of all geriatric planning.

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