Private Insane Patients.

The contrast in the stated number of private patients in the three kingdoms has long been a striking one, and the causes of the difference are worthy of consideration by all who are interested in the treatment of the insane. Probably the same causes are at work in all parts, and we propose to leave Ireland out of the question and to seek out their true nature by a comparison of England and Scotland

In Scotland in 1860 the proportion of private to total number of patients was about 1 in 6, and has fallen to about 1 in 7 in 1900, *viz.* 2214 in 15,475. In England the same fall has occurred, but in increased ratio, *viz.* from 1 in 8 in 1859 to about 1 in 12 in 1902.

The census returns in regard to the housing of the people and the income tax statistics both show that there is a considerably larger proportion of well-to-do persons in England than in Scotland. The expectation from this would be that there would also be a larger proportion of private patients and not the reverse, as the figures given above show.

Dr. Clouston, in adverting to this question in his 1900 report, states as a curious social fact that "the moderately well-off Scotsman supports his insane relations without letting them fall on the rates in twice the proportion that the Englishman does, etc." It is the case certainly that the proportion of private patients to total patients was on January 1st, 1901, 1 to 6·98 in Scotland and 1 to 12·05 in England; also that private patients were on the same date in proportion to pauper patients as 1 to 5·98 in Scotland and 1 to 10·95 in England, but, to our mind, these figures do not warrant Dr. Clouston's reading of them. From those given below it will be seen that the proportion of private patients to population in Scotland is getting on for twice as much as it is in England, while the proportion of pauper patients is almost identical. It might be equally well assumed that both nations desire to be independent of the rates, but that Scotland has relatively twice as many private patients to whom she can do her duty. Further, we find that about 1 in 41 Englishmen and 1 in 44 Scotsmen are in receipt of relief in one shape or another. We are therefore driven to the conclusion that the difference in private

lunacy statistics is due to circumstances rather than to individual or racial habit.

	Population, April 1, 1901.	Pauper patients, Jan. 1, 1901.	Private patients, Jan. 1, 1901.	Total patients, Jan. 1, 1901.
England . .	32,526,000	98,223	8947	107,920
Ratios to population . . .	—	1 to 331	1 to 3635	1 to 301
Scotland . .	4,472,000	13,261	2214	15,475
Ratios to population . . .	—	1 to 337	1 to 2019	1 to 288

What are the circumstances? To begin with, we find that in each of the Royal Hospitals at Dundee, Edinburgh, and Montrose there is a special or district rate for private patients actually, and in one instance substantially, lower than the pauper rate for the district. We do not suppose that this fact has a very far-reaching influence on the proportions in question, but it must be discounted. Then at most of the district asylums private patients are admitted at pauper rates, or for a sum but little above. Until recently such a system was almost unknown in England. Then there can be no question that in the middle of last century the Royal Asylum in Scotland offered accommodation for patients just above pauper condition to a far greater extent relatively than could be found in England, and for that deserves all honour. The tendency to keep up that class of accommodation still exists, for has not Gartnavel totally excluded paupers in favour of such cases? and is not Morningside eager to get rid of its City paupers for the same reason? The true solution of the question seems to lie chiefly in the amount of accommodation thus available, and it can be summed up thus: Given accommodation for private cases who without it would go on the pauper list, occupants will be certainly and quickly found. The truth of this has been shown not only at Gartnavel, but also in England. The accommodation specially provided at Dorchester, Claybury, and Stone for private patients apart from others is full and overflowing, and the increase of private patients in each of the London County Asylums since they have been admitted on payment of the bare maintenance rate, though

small at present, points the same way. Yet again, the transfer from pauper to private classes yearly and increasingly exceeds those from private to pauper; in fact, it may be confidently said that if a *quid pro quo* is given many will make a slight extra effort to have their friends ranked as private patients, who would not feel justified in finding an additional four or five shillings per week for nothing.

Another question arises: whether for the class of patients just above those last described as much is done by the Registered Hospitals in England as is done by the Royal Asylums of Scotland. Our impression is that in relation to numbers there is less scope in England, but it is hard to say so certainly without the actual figures of number and rates of payment in each case. The same want of information prevents our even guessing at the accommodation afforded for such cases in private asylums, though a glance at the numbers in those which may be supposed to take them in would suggest that there is not much room to spare.

For the richer patients there seems to be ample accommodation in England, and probably in Scotland. But this class is not likely to extend very much, certainly not to the extent of influencing the equalisation of the ratios now being considered.

On the whole we consider that we are justified in concluding that England would show as goodly a proportion of privately supported patients as Scotland does if it only had the machinery. It is possible that the extension of Registered Hospitals, such as is now taking place, for instance, at Cheadle, will supply some of the provision required, but for the bulk of that provision we must look to County Councils. We earnestly hope that if the latter bodies are persuaded to take up the task generally it will be with a stern determination not to go beyond the best available treatment *plus* moderate comfort suitable to the financial circumstances of those to be admitted. Anything like a brave show or a rivalry in grand buildings, such as is not altogether unknown even in pauper asylums, will infallibly damn the enterprise. Such institutions or additions should be conducted on absolutely even principles, the same treatment for all alike, any difference therein being dictated by the medical emergencies of a case and not by payments. The payments should be just as much as will cover maintenance *plus* repayment of capital cost. When the latter ceases in

the course of years there will then be room for either modifying terms or for benevolence to deserving cases. The word "profit" should not be heard in connection with the enterprise.

The Report on the Dieting of Pauper Lunatics in Scotland.

One of the most important and valuable documents that has ever been issued in connection with the institutional treatment of insanity is the *Report on the Dieting of Pauper Lunatics in Asylums and Lunatic Wards of Poor-houses in Scotland*, by Dr. J. C. Dunlop. It is issued as a supplement to the forty-third Annual Report of the Scottish Commissioners.

The results of the investigation, planned and carried out in a thoroughly scientific and practical manner, must have a wide-reaching influence on the dietaries of the insane, not only in Great Britain, but in other countries.

Whatever criticism may be advanced in regard to details of the estimation of dietetic values, etc., there can be no doubt that these closely approximate to the truth, there being found to be a close correspondence between the estimated values of diets and the general nutrition of the patients.

The few exceptions in which a diet of low nutritional value is found to correspond with an average nutritional weight of the patients will probably be found to be accounted for by exceptional or unrecorded supplies of food, or possibly by exceptionally good preparation of the food, and, indeed, to be exceptions which help to prove the rule.

The suggestions for ensuring the proper feeding of pauper insane patients, with which Dr. Dunlop concludes his report correspond very closely with the principles that have long been followed in most of the best asylum dietaries, but it is of distinct importance to have these principles confirmed on a scientific basis, as given in this Report.

A detailed criticism of the Report has yet to be written, but the Scottish Lunacy Commission is to be congratulated on having undertaken a most important piece of work, which has long needed attention, and on having entrusted its execution to the care of so able and competent an investigator as Dr. Dunlop.