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Part I.—Original Articles.

MENTAL OBSERVATION WARDS:
A DISCUSSION OF THEIR WORK AND ITS OBJECTS.

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INTRODUCTION.

FOR many years it has been the policy of the London Authority to avoid the certification of patients directly from their own homes, by passing them through an observation ward before making a decision as to their disposal. The system originated partly from the fact that the London Mental Hospitals are some distance from town, and partly from the shortage of accommodation, it being necessary to secure the safe custody of the patients pending their admission. The small scattered wards have now been fused together to form larger and more efficient units, which ensure every case having the fullest consideration and investigation before deciding upon any method of disposal. The various points arising in this paper are illustrated by reference to the work of the largest of these units.

We feel that to the psychiatrist a description of the extraordinary variety of patients passing through an observation ward, the procedures involved in their sorting and distribution and the figures of their ultimate place of disposal might prove to be of interest. By incorporating these points in a discussion of two recent publications, we hope that the paper may have a wider scope and perhaps be of some practical use.

In the Maudsley Hospital Medical Superintendent's Report, 1932–35, it is shown how the development has taken place of "a co-ordinated system of dealing with mental and neurotic diseases of all kinds, and degrees, and at all stages". In Section 1 we have attempted to outline the place of the

This one

observation ward in this scheme, and to describe briefly the management and planning, and the steps taken to avoid mixing cases that might adversely affect one another. Various other references to this report will be found in the different sections.

The Board of Control's Report for 1935 (Part I) contains several references to the observation wards in municipal hospitals and institutions. The investigations of these, it says, is disquieting on the whole ; in some, newly admitted patients are mixed with chronic cases and low-grade defectives, and the staff have not had the training necessary. Reference to this criticism, as mentioned above, is made in Section 1.

The latter report begins by stating that the overcrowding in mental hospitals is more serious than the net figures suggest ; and adds later—" Once it is clear that the patient requires treatment for mental illness, no time should be lost in transferring him to the mental hospital, which in general is the only place able to provide the specialized experience and the therapeutic resources necessary for successful treatment ". Both these points are raised in Section 2, which discusses the advisability of immediate transfer, the procedure in regard to each individual case, and the powers of the visiting Justice of the Peace.

A classification of the various types of disorders in the admissions is given in Section 3 as a matter of interest. The vast majority were genuine cases of mental illness, each clearly in need of treatment, but surely one is not to transfer them all to mental hospitals ? The above statement from the Report must, in spite of its definite wording, be somewhat broadly interpreted.

In Section 4, which relates to the disposal of cases, the figures are analysed. The points in the report with reference to the Mental Treatment Act, and the use of temporary treatment in particular, are considered.

Finally Section 5 is devoted to a short discussion of some conclusions and proposals which have arisen in the work.

In this paper it is suggested that well-organized observation wards, situated within easy reach of the most populated areas, can deal suitably with doubtful cases coming to general hospitals and local doctors. Also, that it would no longer be necessary for relieving officers, police and other officials to have to make a decision in suspected cases of mental disorder brought to their notice. Some modification of the system might have to be made in rural districts. Moreover, the observation wards can obviate the difficulty of deciding the line of action to be taken in the event of further treatment being necessary, and diminish the number of people unnecessarily certified.

In addition, we believe that if certain cases were adequately dealt with during the temporary powers of detention in a well-organized observation ward (at present limited, by a relieving officer's 3-day and a medical officer's 14-day order, to 17 days), they would have no need of mental hospital treatment. A further passage from the Board of Control's report runs : " Every improvement of the observation wards increases the temptation to undertake active

treatment, a practice quite inconsistent with the main purpose of such wards, which is the diagnosis of doubtful cases." Whilst agreeing with this statement for most observation wards at present, we believe that in the future reasonably large units will provide an adequate classification of cases, and give the opportunity for time, skill, experience and patience to be used, to gain the co-operation of the patient and avoid his transfer to a mental hospital. Whatever the views expressed as to the advantages of the latter may be, there can be no doubt about the objection of patients and their relatives. Moreover, in transient psychoses, whether volitional or not, recovery can take place with efficient treatment in the observation ward, enabling the patient to return to his daily routine, perhaps with the aid of an out-patient clinic. In chosen cases we believe that time should also be given to regain volition, or insight and better judgment, so that the patient may then co-operate with the doctors and authorities.

The following description refers to an advantageously placed observation ward in the service of the London County Council, and includes an analysis of the types and their relative numbers among over 1,100 admissions in a little more than a year.

Section I: Description.

The mental block was under the administration of the Public Health Department of the London County Council, and the largest of such units. It consisted of 82 beds disposed in two similar male and female blocks, renovated in recent years with the object of taking over the work of several smaller wards in other institutions and hospitals. About 1,000 cases a year were thus dealt with. Adjoining, and under the same administrative control, was a large general hospital and a chronic sick institution.

The unit drew its patients from two public assistance areas. The one with a population of 436,893 supplied 447 cases to this ward in a year and 184 to others; 113 of the patients were certified. From the 296,147 inhabitants of the other area, 123 of the 482 admissions during the time were certified.

In each block new cases were admitted to a ward of ten beds for preliminary observation; adjacent to it were two shuttered side-rooms, two warmed and lighted padded rooms, lavatories and a bathroom with continuous bath. Thus this portion was self-contained, and so avoided the disturbance of patients in the remaining wards.

Padded rooms are often condemned, but they prove especially useful in this work for really violent and for restless senile patients; moreover they diminish the number of staff who would otherwise be required to keep the cases in bed, and save the extensive bruising which is bound to arise if this is done, besides avoiding an atmosphere of antagonism and unrest which is always bred by constant skirmishings.

Padded beds with high sides, as used in certain of the L.C.C. observation

wards, covered in by netting if necessary, have much to recommend them, if used in addition to, rather than in place of padded rooms. They should be used in a single room to avoid disturbing and perhaps frightening other patients. They have several distinct advantages: they allow less freedom than does a padded room, and thus there is less chance of injury, observation is easier, struggling upon entry is no longer necessary, and the room may be used as an ordinary side-room when not required by the excitable or restless type of patient. On the other hand there is probably more difficulty in keeping the patient clean, and the excessive restriction may upset certain cases who settle in the ordinary padded room, perhaps without seclusion. It is to be noticed that this method of dealing with excitable cases does not constitute a form of mechanical restraint.

Another rather larger ward was reserved for quieter bed cases; there were, in addition, kitchens and offices on the ground floor. Above these was a further dormitory and a comparatively large recreation room with facilities for ping-pong, various other table games, a wireless set and a piano. It was decorated with attractive bright pictures, framed copies of pictorial railway posters, which lend themselves admirably for decoration of this kind. An airing garden provided daily exercise. The size of the wards, the mixed types of cases and the rapidly-changing patients render the usual forms of occupation therapy inapplicable. The nursing staff do most valuable work in encouraging light simple handwork, and various forms of useful employment, on the medical officer's advice; in most cases any but the very lightest forms of domestic duties are not advocated.

The medical officer in charge had had several years' experience in the Council's mental service, and was seconded to the unit; incidentally he received a fixed salary, and had no remunerative interest in the disposal of patients under any form of recommendation or certificate. He was aided by a second medical officer and a trained psychiatric social worker.

The majority of the nursing staff were certificated in mental work or had had mental hospital experience. A relatively large staff is necessary because of the different and constantly changing types of case. Their work is more difficult than that of the nurse in charge of most of the more permanent occupants of mental hospitals, as they have continually to adapt themselves to new patients. Considering this, at least a portion of their necessary training must be in the observation ward, and we expect that in the future a period of such service will considerably enhance a nurse's qualifications. As in mental hospital routine generally, the maintenance of a good tone conducive to the patients' self-respect is desirable in observation wards, and the attitude and manner taken up by the staff towards the patients individually and generally should be one of civility and sympathy.

This unit was singularly fortunate from the viewpoint of investigation and prognosis in having the facilities of specialized advice and treatment adjoining,

in all branches of medicine and pathology, and the opportunity for interchange of cases with the acute and chronic sick wards.

The proximity of the Maudsley Hospital, with its special annexe at King's College Hospital, provided facilities for close mutual co-operation. Thus, cases were sent there as in-patients, others on discharge went to the out-patient clinic, and many were admitted from the latter department for transfer to mental hospitals.

The Medical Superintendent of the Maudsley Hospital visited as Consultant twice weekly, and gave advice on the difficult cases, patients with a hopeful future and those electing to go away for voluntary treatment. In addition he saw about 100 other cases each year sent from the general hospital for his opinion.

On the other hand, from the point of view of the mental hospital, we made an attempt—

(*a*) To decide the disposal of cases with due regard to their prognosis. Thus patients who were likely to recover in the course of a few days were kept in the ward.

(*b*) To use the legal processes of transfer in such a way that re-grading would be unnecessary.

(*c*) To transfer patients in as good a state of physical health as was possible.

With regard to this last point, the state of neglect in which a large number of cases arrive at the observation ward is unbelievable to those who do not admit them. This applies particularly to some senile patients who have been living alone. Their clothes have not been taken off for months, they are alive with vermin and filthy with excretions. Their mouths are dirty, they are half-starved, constipated, bronchitic, anæmic and toxic. It is a wonderful tribute to the nursing staff that there is such a magical change in the patient's condition so soon after admission.

Thus the observation ward, instead of being small, isolated and ineffective, has come to be, we believe, a useful part of the machinery for dealing with mental disorder.

Section II: The Management of Each Case from Admission to Discharge.

Most of the cases were admitted by one of the following procedures:

1. A relieving officer of the district supplied a legal detention order lasting for three clear days (Lunacy Act, Sect. 20) unless the patient was discharged within this time by the justice of the peace. In a series of 500 consecutive cases, 378 (or 75%) were thus admitted, including 33 cases of attempted or threatened suicide and 2 of homicide.

2. Police officers gave a similar order admitting 54 cases (or 11%). These

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were usually more violent, and amongst them were 12 suicidal attempts (4 by drowning), 12 who were found wandering at large, 8 cases of violence, 7 alcoholics, and 6 who were behaving in an odd manner.

3. An institutional medical officer's order in writing (Lunacy Act, Sect. 24 (1)), which would detain a patient for fourteen days. These entries came from the general hospital through the chronic sick wards, or from them directly. This order, moreover, was used to detain the patients in the observation ward when the Justice made " no order ".

4. By the order for pauper lunatics wandering at large (Lunacy Act, Sect. 15). There were only two such admissions.

5. A few entered of their own accord ; this is an interesting development, and shows an increasing confidence in the treatment, and an absence of that horror with which the public are supposed to regard the experience. If a person enters an observation ward in this way, he is under no obligation to give any period of notice before leaving, and is not recognized under the legal status of a " voluntary patient ". For this reason the system is obviously open to abuse, and judgment has to be exercised, otherwise it would become a simple method of obtaining a night's lodging. Actually this did not concern us, for the only patients thus admitted were from the administrative unit.

A Justice of the Peace (on a rota of duty) visited the ward three times weekly and saw all cases within three days of admission, and others of longer standing, submitted for legal certification. He either made an order for the patient's reception in a mental hospital after interviewing him and considering the medical officer's certificate, or alternatively he made no order and signed a book to that effect. He nearly always asked the medical officer's advice, and generally it was accepted. Evidence was supplemented by police or relieving officers, and the relatives, whose views as to certification and treatment were considered, after the position and the procedure advocated had been explained to them. An experienced justice would adequately stress the possibility of serious consequences arising if the advice were not taken, and he could be a great help with certain relatives, who sometimes presented greater problems than the patients themselves.

Certain types of case are best certified without delay, and 45 of our series of 1,156 were dealt with thus within the first three days of their admission. Sometimes it was difficult for such reasons as the following :

(1) Some cases had been certified before and knew the routine, consequently they were not prepared to give themselves away to the Justice of the Peace, at least on their first interview.

(2) Suicidal or homicidal patients might conceal their intentions.

(3) Paranoid patients might undergo temporary improvement on change of surroundings.

On the other hand, it was one of the first principles of disposal not to transfer a patient to a mental hospital if it could be avoided. Acute cases

nearly always showed a rapid improvement. A very remarkable case illustrating this point was a post-influenzal hallucinosis who chased lions and picked strawberries from the walls of the padded room, but recovered two days later and did not relapse. (This was his first illness and there was no alcoholic or drug history.) Alcoholics needed some days' treatment, but were usually uncertifiable after a very short time.

If all patients of these last two types of case were transferred because of an acute transient psychosis or delirium, a large number of patients would be sent to mental hospitals unnecessarily. It will be seen in Section 4 that it was possible to discharge about a quarter of the total admissions, usually by the end of seventeen days, thereby avoiding an enormous burden on the already overcrowded mental hospitals.

Those cases best certified eventually, such as the first three examples, have often to be watched carefully for days, or weeks, before their true psychotic nature is revealed.

At his first interview with the patient the Justice usually made "no order", and a medical officer's fourteen-day order was completed, giving up to a total of seventeen days in which to diagnose, treat if necessary, and form a reasonable prognosis of the case.

At the time of the patient's admission to the observation ward a short history was taken from the relieving officer or police, and the relatives or friends. A reasonably thorough physical examination was made, notes taken of injuries, and as soon as possible, some details of his mental state. After bathing, the patient was put to bed in the admission ward for observation, and reports were made by the staff on his conduct, tendencies, delusions and hallucinations.

The medical officer's first duty was to decide the following questions in the light of the past history and present type of illness:

(1) Was it justifiable to certify the patient immediately?
(2) Was he an obvious case to go away as a voluntary patient?
(3) Would he make a suitable temporary patient?
(4) Was he in need of treatment at a hospital for senile cases?

If these questions could be definitely answered no time was lost in making the necessary arrangements, as suggested in the Board of Control's Report. The majority, however, gave no such clear indications, and needed further investigation and observation before these points could be decided.

In cases other than those certified within the first three days fuller mental and physical notes were made, and routine Wassermann reactions and any other pathological examinations thought necessary were done. They were treated for such conditions as insomnia, constipation, dehydration, oral sepsis and gross cardiac or pulmonary disease, special attention being paid to the confusional and delirious cases. Most cases improved to an extent whereby the underlying psychosis was revealed, allowing a fairer prognosis and classification to be made. The indiscriminate use of sedatives merely for the sake of keeping

the patient quiet was regarded in much the same light as is giving morphia to one with an acute abdomen before a diagnosis is made or indication for operation is clear. The questions of bromides will be discussed later.

In some cases encouragement and suggestion were employed, co-operation gained, and with the help of the change of surroundings, rest and recreation, insight was obtained. By this means a large proportion would either go as voluntary patients to mental hospitals (if not discharged home as recovered), or if they improved sufficiently were put under out-patient care at the Maudsley before, or soon after, seventeen days.

As stated above, the wishes of the relatives were usually fully considered, to gain their co-operation, and to remove the fears which are often associated with mental hospitals. The friends and relatives like to think that there is nothing "mental" about the patient, but that the cause of the trouble is merely a "nervous breakdown" or "nerves", however bad he may be, and what the neighbours may say often counts for a good deal. In this connection it is to be noted that the London County Council have recently changed the names of their mental hospitals, omitting the "mental" portion. This is an improvement, but much public re-education will have to take place, in addition to changes in the system of dealing with mental disorder, before the hospitals are generally accepted.

The social worker investigated the history of many of the cases, often interviewing relatives or friends in their own homes, so that a better idea of the domestic conditions could be obtained. A shrewd but tactful and pleasant manner in the experienced social worker will enable her to detect unreliable or inadequate statements given by frightened or difficult informants. The worker trained in psychiatry will note schizophrenic, paranoid or other relevant symptoms given in the story of the patient's habits of life and the circumstances leading to admission. She will also obtain a family history, the details of the patient's early life, his work and his financial position, and set it out in a concise form. A copy is kept with the patient's notes, and a duplicate is sent to the hospital to which he goes. Such a history is essential in making a reasonable prognosis in a border-line case; it does not differ much from the work done at the mental hospitals, but has to be completed within a short time. The medical officer has not the time necessary to do such work as efficiently as can the social worker. She is also invaluable in making arrangements for patients going away on a voluntary basis to mental hospitals or to After-Care Association homes. Often she can place those who are in need of a home or hostel but not of mental hospital treatment, or even find suitable employment for some cases. She can keep in touch with patients who may relapse after discharge, and this in the observation ward work is a very important part of her duties. She can co-operate with social workers in other hospitals, obtain all sorts of odd information, such as is done by the Lady Almoner in general hospitals, and keep "follow-up" records.

When the history of the patient and his examination were completed he was seen by the consultant psychiatrist, who gave a prognosis and advised upon disposal, or suggested further investigations and observation.

Young people in their first attack always received special consideration, and the social worker could help a great deal by following them up. The alternative methods of disposal, which will be discussed in more detail in Section 4, where the results are analysed, were briefly these :

1. To go home, or to an after-care or convalescent home, perhaps after a slightly extended period in the ward on a voluntary basis.

2. To go to a general hospital, an epileptic colony, special home, hostel or institution.

3. To go as a voluntary patient to the Maudsley or to a mental hospital.

4. To be recommended as a temporary patient.

5. To be certified (under the Lunacy or Mental Deficiency Acts).

6. To be sent to a hospital for senile cases. In the London County Council service there is a special hospital for the more docile type of senile patients.

Section III : The Type of Case Admitted.

Although some of the groups of a classification must overlap, the following brief scheme gives an idea of the types of cases admitted, and their relative numbers. The figures below were found for the 518 cases with which one of us dealt :

	Males.	Females.
1. *Mental deficiency*	10	2
2. *Organic nervous and mental disorders :*		
a. Senile changes	52	52
b. Cardio-vascular :		
1. Heart failure	6	3
2. Other conditions	7	2
c. Various gross central nervous system lesions	8	6
d. Epilepsy	12	4
e. Neuro-syphilis :		
1. Interstitial	2	1
2. G.P.I.	10	6
3. Tabes	1	1
f. Infections, endocrine and other physical disorders	14	9
g. Alcoholism	27	18
h. Bromide intoxications	4	6
i. Confusional states of doubtful origin	7	7

	Males.	Females.
3. *Depressive states*	32	53
4. *Manic states*	11	21
5. *Schizophrenic states*	48	41
6. *Moral abnormalities*	3	3
7. *Psychoneuroses*	8	8
8. *Institutional cases*	12	1

Syphilis.—Of the 274 male cases 24 had a positive blood Wassermann reaction, but only 10 of these were general paralytics. Two had interstitial syphilis (one an amyotrophy) and another was a tabetic. Among the 224 females there were 13 with a positive blood Wassermann reaction. Six of these were general paralytics, one a tabetic and one a case of cerebro-spinal syphilis.

Three of the 16 general paralytics died before having treatment, 2 had previously been unsuccessfully treated with malaria, whilst 2 others refused treatment and were not certified. Of the 9 who went away for malaria therapy, 3 made a good recovery.

Alcohol.—Three males and 4 females were admitted in a state of intoxication secondary to a psychosis, and all went to mental hospitals.

These are not included in the above figures for the alcoholics. The total number formed nearly 10% of the admissions, and were interesting in being so different from the ordinary inebriated person that they were brought for observation. The relative forms of the disorders in the sexes were:

	Males.	Females.
Delirium tremens	4	1
Confused, hallucinated and paranoid	15	12
Alcoholic pseudo-paresis	2	—
Amnesic and demented	2	5

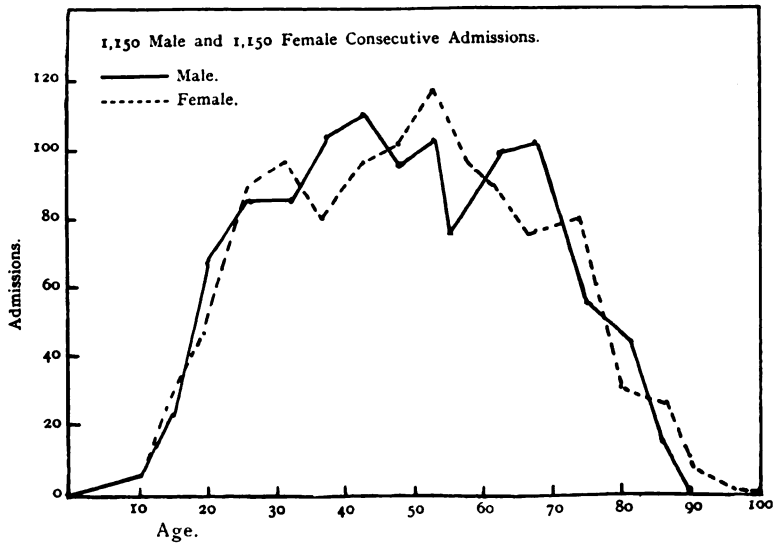
Three of the males were certified and 2 went away as voluntary patients. Five of the females were certified. In addition, 4 old men (3 over 75) were brought in after "celebrations" and later discharged.

A point to which much recent attention has been paid is "Red Lizzy" or "Red Biddy" drinking. We could find 2 males and 7 females who drank little else than cheap red wine; in no case were there any eye signs, nor in fact was there anything typical about them other than this strong addiction. It seems that some confusion arises in the distinction between "Red Lizzy" on the one hand and cheap colonial red wine and Lisbon wine on the other, and that they are wrongly called by the same name. "Red Lizzy" was originally described as cheap red wine to which methylated spirits had been added by the drinker, though it has never been found to be sold in this way.

Bromide intoxication.—Routine blood bromide estimations were made on the last 240 admissions: 14 of these were higher than 150 mgrm. %. Each of

these patients was given oral saline, and those above 200 mgrm. % rectal salines in addition. It is surely a very suggestive, though not conclusive, fact that 4 of these 14 cases died within three weeks of admission! Their ages were 76, 67, 63 and 52, and their blood bromides 175, 160, 150 and 210 mgrm.% respectively. Within this period 81 other patients aged 60 and over were admitted and only 7 of these died. After a variable time in the ward 5 of the 14 cases recovered sufficiently to return home.

The statements made upon the increasing facility of intoxication with age appear to be well confirmed by these observations.



Other cases of note.—Among the gross central nervous system lesions there were cases of cerebral tumour, cerebral angioma, head injury, disseminate sclerosis, Huntington's chorea and Parkinsonianism.

The sixth group, among the organic disorders, contained patients with phthisis, post-operative disturbances, hyperthyroidism, myxœdema, Simmond's disease, acromegaly, jaundice, uræmia and diabetes.

Pathological liars with some transient hysteria (usually young women), and social problems such as police-court cases, the homeless and the friendless, found their way into the ward from time to time.

Institutional cases.—It will be seen that a separate group has been made for the cases coming in, for instance, from casual wards, institutions, and the streets. A few were obvious malingerers; others, people who needed some supervision, the types who went in and out of jobs, but were usually unemployed, and for whom one could do little to help. These were clearly unsuitable cases either for the mental hospital or for the observation wards and they were usually rapidly returned to the place whence they came.

Age-incidence.—It may be of some interest to show the age-incidence of the admissions, which perhaps gives a truer distribution than the figures taken from those cases going to mental hospitals. The curve below is the result of plotting the mean ages against the admissions for each five years (*e.g.*, age 23–27 as 25, 28–32 as 30). To give it more value, we have added the 1,100 previous cases to our own (see diagram, p. 357).

Section IV: The Disposal of Cases.

The various alternative methods of disposal have already been mentioned; the following figures are quoted from 1,156 cases (638 of one writer and 518 of the other). The numbers were reduced by local circumstances, such as the temporary overcrowding of the hospitals for senile cases; these patients occupied for lengthy periods many beds which would otherwise have been used for younger psychotics. Cases from our own areas had at times to be sent to other observation wards, in consequence of this congestion. In the analysis below the writers (one of whom followed the other in charge of the ward) worked independently without having the present paper in view. The agreement of the figures is so remarkable that the percentages are quoted independently under columns 1 and 2.

	638 cases. I. (%.)	518 cases. II. (%.)	Combined number.	1,156 cases. (% gross total.)
1. *Discharged home* before or after 17 days in the ward	25·4	24·3	288	25·0
2. *Voluntary patients:*				
a. To mental hospitals	10·6	10·5	122	10·6
b. To the Maudsley Hospital	4·5	4·2	51	4·4
3. Mental after-care convalescent homes	3·0	2·9	34	3·0
4. Temporary patients	0·3	2·1	13	1·1
5. Certified (99% L.A. 1% Mental Deficiency Acts)	27·9	28·2	324	28·0
6. Senile: (*a*) to Tooting Bec Hospital (for senile cases); (*b*) died in the observation ward	11·2	10·8	128	11·0
	5·6	5·8	66	5·7
7. To acute or chronic sick wards (of the general hospital and institution)	8·4	8·3	97	8·3
8. Died (not senile)	2·8	2·5	31	2·6

(1) It will be noticed that some remained in the ward on a voluntary basis for a longer period than the seventeen days (limited to a further fortnight, except in very special circumstances, otherwise the congestion would have become unmanageable.

Most of these patients (105 out of 288 discharges) were fit to return to their usual routine, while some attended the Maudsley Out-Patient Department. If they had gone on to mental hospitals the percentage of voluntary patients would have been greatly raised.

Among the reasons for remaining in the observation ward, as an alternative to voluntary treatment in a mental hospital, were (1) that men might lose their work if they did not quickly return; (2) certain of the relatives influenced patients against going to a mental hospital; (3) to other patients the name "mental hospital" signified something which they felt applied to cases worse than themselves.

Also included in this section are several cases discharged to institutions or hostels whose relatives would not have them back, or who had previously lived alone, but who now needed supervision.

(2) It is considered that the most suitable types of voluntary patients were:

a. Minor recoverable psychoses and neuroses.

b. Major recoverable cases, particularly melancholics.

c. Docile schizophrenics.

d. Chronic neurotics.

Many patients in the first two groups were suitable for admission to the Maudsley Hospital.

It has been said that anyone who is certifiable but willing to go as a voluntary patient is suitable for such treatment, but all such cases cannot be recommended. For instance, some with a bad history and outlook should not be encouraged to go as voluntary patients, since in all probability they would not stay long enough to improve. This is not always appreciated by Justices. Those belonging to the types we believe to be "justifiably certifiable" were usually certified; in some of these cases it was difficult to secure enough satisfactory evidence of insanity during their stay in the ward, and a few had to be released to their protesting relatives. On the other hand, a few apparently suitable voluntary patients were returned within a few weeks recommended for certification; these were usually schizoid cases of whom the worst had not been seen.

(3) This group contains those patients unfitted on the one hand to go to ordinary convalescent homes, and on the other not needing mental hospital treatment or a further period in the observation ward. The Mental After-Care Association's convalescent homes are particularly useful for depressive cases who have recovered in the ward, perhaps after a suicidal attempt, and hence need more freedom under some supervision before returning to their normal duties.

(4) Our figures for the cases sent as temporary patients show a considerable difference; this is because we set out to test entirely different experimental ideas on the Act. In the light of recent discussion on this matter the results may be of interest:

(*a*) In 638 cases one of us estimates that 23 acute non-volitional patients with fairly reasonable prospects of early recovery, might have been sent as temporary patients within the first week of admission. They were, however, kept in the ward instead of being dealt with at once under Sect. 5 of the Mental Treatment Act. It is of interest to note what followed. Of these 23 patients, 10 were returned home fully recovered within two to six weeks; 10 became voluntary patients at the mental hospitals, 2 were certified, and 1 died from sudden cardiac failure. Other confusional and non-volitional cases were numerous, but quite unsuitable to be temporary patients. These were certified, because of a bad previous history of mental abnormality, particularly if long-standing and unremitting, or perhaps of a "difficult", dangerous or unreliable type, or if markedly schizophrenic, paraphrenic or paranoidal; again this was the best procedure in the presence of progressive or irrecoverable organic disease, including the pre-senile degenerations, of which there were many amongst the confusional and maniacal cases admitted. Briefly those who were not likely to be discharged or become reliably co-operative after a reasonable period or treatment in a mental hospital, whether regaining volition or not, were considered to be unsuitable as temporary patients. Two entirely suitable cases were sent away under this section of the Act.

(*b*) In the 518 cases of the other writer, an attempt was made to send every strictly non-volitional case away as a temporary patient providing (i) his chance of recovery was good, and (ii) he was not expected to become volitional for some weeks. Only 11 such cases were found. Two are still temporary patients, 6 have recovered (in 11, 9, 5, 5, 2, 1 months respectively). Two became voluntary patients (one of these is almost fit to be discharged, and the other left, but was later certified). The eleventh was certified after two months.

Two conclusions may perhaps be drawn from these results: the first that an extraordinarily small number of patients are really suitable for temporary treatment unless this section of the Act is stretched beyond its clear legal meaning; secondly that after two or three weeks of treatment in an observation ward the percentage of cases for which the Act, strictly applied, can be used is negligible. However, since they either recover, or go away as voluntary patients, it does not seem to matter much.

(5) The figure of 28% for certification is in our estimation still rather high. It would be considerably and justifiably reduced if further use could be made of the observation wards as treatment centres, and if one further detention order beyond the usual fourteen or seventeen days could be made, say, on the consultant's written advice, in non-co-operative but nevertheless recoverable cases.

The Board of Control Report (1935) states that hopes are held that eventually only one-third of all cases admitted to mental hospitals will be certified.

It is interesting to find that in a previous year, but after the Mental Treatment Act was passed, for a series of 212 consecutive admissions to the wards, 55% of males and 58% of females were certified. Certain types are probably always best certified; among these are patients with a bad social history or criminal tendencies, paranoid, schizoid or dementing cases who seem likely to be permanent and are not amenable to voluntary treatment; mental defectives with a superadded psychosis, dangerous senile cases, and some with organic disorders refusing voluntary treatment.

The above statement from the Board of Control's Report seems to be utterly inconsistent with the view also emanating from the same source, indicating that not enough use is made of the Urgency Order (extended to rate-aided patients by the 1930 Act). This Order obviously applies to the very acute cases, yet it seems quite clear that these are the cases that often quickly recover in an observation ward, and consequently have no need of mental hospital case.

A second point is that if it is decided to transfer these cases to mental hospitals, they are the very patients who provide most of the suitable temporary patients and have no need of certification.

Thirdly, the Board of Control's Report states the purpose of the observation wards to be the diagnosis of difficult cases. Are not these the patients who provide the greatest difficulty to those not often seeing such types? Moreover they are the most likely to be confounded with organic disorders unless given the opportunity for hospital investigation. Those patients to whom the observation wards can give the greatest assistance are unnecessarily side-tracked by using the Urgency Order.

It would seem clear then that the observation ward is the essential unit in the present system, not only for reducing the numbers certified, but for avoiding their transfer altogether, which is a far more important matter from the patient's point of view.

(6) Nearly a third of the total senile admissions died, some of them within a short time of coming into the wards. The removal from home or hospital seemed unnecessary in some cases; on the other hand this might well have been due to the fact that they quickly settle down under the observation ward routine.

At present they hamper the true work of an observation ward, and it is to be hoped that it may be possible at some future date to send them directly from hospitals or their homes to the special hospitals for seniles, and that some such institution or part of the present ones may take the troublesome and dangerous types.

The Maudsley Hospital Medical Superintendent's Report states that "the rising prestige of the mental observation units is producing great changes, which will grow further when it becomes possible to clear them of the senile cases which now so greatly reduce their capacity". Observation wards are

unnecessary for the diagnosis and disposal of most of these cases, and they are unsuitable companions for young psychotics, and especially neurotics.

(7) Reference to this considerable percentage of acute and chronic sick cases is made in the next section.

Section V.

Observation wards are in their infancy so far as their developmental possibilities are concerned—in fact we are still in the process of deciding what their purpose should be.

Returning to the Board of Control's Report, it is stated that the main purpose of observation wards is the diagnosis of doubtful cases, but that they have dangers in that active treatment may be encouraged. We hope this account of the work in an observation ward has shown that it is possible to avoid sending large numbers to the mental hospitals without trespassing upon those cases for which they " are the only places able to provide the specialized experience and the therapeutic resources necessary for successful treatment ".

In order to do this, however, we feel that, in certain cases, active treatment up to that point is to be encouraged, and that in fairness to the patient, it should be practised whilst the diagnosis of difficult cases is proceeding.

The second point from the Board of Control's Report concerning the purpose of the observation wards states: " Once it is clear that the patient requires treatment for mental illness, no time should be lost in transferring him to the mental hospital." Incidentally a point to be considered is that if one is to transfer patients rapidly, upon whom is the onus of the defence to rest if actions are brought for wrongful certification ? We have already stated that it seems unreasonable to hasten some patients' departure to a mental hospital under certificate, when they happen, at the time, to be unwilling to go as voluntary patients. They may often be made to realize the need of treatment within the next fortnight, or may even be able to return home within or soon after their seventeen days' detention. It is a waste of time and bad therapy to suggest to a patient that he may be certified if he does not go to a mental hospital as a voluntary patient, for he will generally agree to give nominal consent in order to effect his early discharge from the mental hospital. Prognosis is an essential factor in making a reasonable classification. The method of saying, " Will you go as a voluntary patient ? " and making him a voluntary, temporary or certified case according to whether he replies " Yes ", gives no answer, or " No ", is not as simple as it sounds. In nearly every case the patient requires time for investigations to be made, and this is where the view of the observation ward as being merely a sorting and clearing station breaks down.

Another reason for delaying the transfer is found in the number of cases later passed on to acute or chronic sick wards. 8·3% of 1,156 patients were thus removed after recovery from a transient psychosis. Had there been no

observation ward these cases would all have gone to mental hospitals, mainly under certificate.

We are now left in the rather awkward position of having to state what conclusions may be drawn as to the purpose of the wards.

Two distinct types of case come into an observation ward. The first group contains the " justifiably certifiable " patients who should be transferred under the Lunacy Acts as soon as grounds for certification can be found; and " obvious " voluntary and temporary cases whose papers should be completed as rapidly as possible. This is as suggested in the Board of Control's Report.

The second and much larger group needs investigation, and should, we believe, be to some extent actively treated. Some will recover and go home before seventeen days, or after a short extra period on a voluntary basis in the ward. Others will improve sufficiently to be made into good voluntary patients. A number will settle down from a transient psychosis sufficiently to go to general wards for the treatment of their physical illness. The institutional cases and social " problems " have to be disposed of individually as thought fit, though in the future systems will probably be evolved for dealing adequately with these cases. Finally a greatly reduced number eventually need certification under the Lunacy Act.

The observation wards provide ideal subjects for teaching purposes. In the Maudsley Hospital Medical Superintendent's Report it is stated that the need of acute cases for study could, in the future, be met largely by the observation ward, in which the cases are of such a kind that experience of them cannot reasonably be omitted from either undergraduate or post-graduate training in psychiatry.

Lastly the observation ward has a purpose in providing excellent research material; and an opportunity is here available for the treatment of cases at their onset.

Few observation wards in other counties have consultant psychiatrists, officers and staff experienced in mental diseases, and all prognostic aids, including social histories, although some are placed conveniently near to a general hospital. There are many practitioners in all parts of the country who would welcome the facilities of such a unit within easy reach; and the responsibility of disposal, especially of certification, could be borne by officers under the local authority. This would diminish overcrowding in the mental hospitals, increase the percentage of voluntary and temporary patients, and add a useful and necessary link in the organization of the mental health service.

The greater the number of relatives and patients that one sees, the more certain does one feel that the whole outlook on mental disorder will have to undergo great changes before it can be fair to transfer or advise the voluntary admission of a patient to a mental hospital, unless this is absolutely essential. The form of admission does not matter nearly so much as the fact that he goes

there, even though "mental" is omitted from the name. There can be no doubt, however, that the patient's future life is less affected by voluntary or temporary treatment than by certification. The re-naming is a step forward, but there are far more important factors to be considered.

A fundamental point in the relatives' outlook is that the patient is going to a hospital where the very great majority of its occupants are destined to stay for life. This is so well known that even the admission villas are inseparably attached to the main hospital in the minds of the public. Again, the London County Council have progressed by devoting a hospital to recoverable cases, other than those voluntary patients going to the Maudsley, though one can imagine that it may be difficult to persuade them to go elsewhere when this becomes generally known.

The ultimate solution must depend largely upon general education as to the nature of the hospitals and treatment, the form of mental disorder, and its regard in the same light as other illness. From this point of view it is instructive to compare the outlook on tuberculosis or cancer. What, we wonder, would be the public reaction to a pseudo-phthisical comedian who made the sanatorium a subject of humour, or who became witty at the expense of a fungating carcinoma? Yet nearly every music-hall programme contains its modern counterpart of the traditional fool.

In the present system of mental treatment it is the observation wards that have the closest contact with the relatives; and it is here that the patient himself makes, or has made for him, a plan for his welfare, which will influence the whole of his future life. Since the observation ward is the smallest and consequently the most flexible portion of the system, it must adjust its working to the requirements of those for whom the complete organization has been evolved, and from this basis nothing but improvement, understanding and smoother co-operation can result.

Summary.

The work in an observation ward which deals with 2·5% of all rate-aided patients admitted to county and borough mental hospitals (which number 23,000 per annum) is described.

The types of cases entering the ward are classified and discussed. The various alternative methods of disposal are considered, in particular Section 5 of the Mental Treatment Act and Urgency Orders, both in their application and value; the figures are analysed.

The writers state that they believe the observation wards to be a useful and essential part of the system of dealing with mental disorder. Their purpose and value are examined with special reference to the Annual Report of the Board of Control for 1935 (Part I) and the Maudsley Hospital Medical Superintendent's Report (1932-35).

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