Part I.—Original Articles.

THE LOW-RATE PRIVATE PATIENT AND SOME CHANGES.

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THE subject of my address is "The Low-rate Private Patient and some Changes". This has been chosen because, for the greater part of my life, my work has been in a hospital unique of its kind, provided by a local authority for those members of the community whose financial position made them independent of the rates, except in the case of mental illness, where the private nursing home was ineligible, and the charges in other hospitals could not be afforded.

Scalebor Park was formally opened thirty-six years ago, and I look back with admiration and gratitude to those who took part in that function: Sir James Crichton-Browne, Sir Frederick Needham, Sir Thomas Clifford Allbutt, Dr. Bedford Pierce, Dr. Major and Mr. Urmston. To the younger generation these may be only names, but they were giants in the land in those days, and all except one of them prominently associated with Yorkshire.

Sir James Crichton-Browne, President of this Association sixty years ago, whose death so recently we deeply regret, observed that he had some personal interest in the new hospital, for it was the realization of a scheme which he had had very much at heart for thirty years.

As Medical Director of Wakefield he had had occasion to notice how persons of the better educated, more refined and more independent class of society, but of limited means, had, for want of other accommodation, to be placed under circumstances which increased their suffering and aggravated their malady. He therefore advocated in the Press the establishment of a lower middle-class hospital. A meeting was held in Leeds, and its purpose was warmly supported and several pounds were subscribed.

The project seemed in a fair way of being carried out. At this moment it was announced that the Government contemplated an amendment of the Lunacy

Laws, and it was considered inexpedient to proceed further until the terms of this were defined.

If the mills of God grind slowly, those of the British Legislature were still more deliberate, and it was not until 1890 that the Act was passed. But at last, after a gestation of thirty years, Scalebor Park was being christened and dedicated.

After tracing some recent advances in our speciality, Sir James went on to say: "But after all, mental hospitals must be looked upon as necessary evils and a blot upon our civilization. The most illustrious of them all would be the one that first performed hara-kiri, the happy despatch, and was able to close its doors.

"The day might come when Scalebor Park would be a moss-grown or ivy-clad ruin, or a manufactory for hydrogen or helium gas, or an almshouse for the maimed victims of motor cars, or serving in some other way the requirements of a new age."

This has been quoted as a matter of history, and in its closing paragraph sounds strangely modern and prophetic in some of its anticipations. The necessity for mental hospitals is, however, unfortunately greater than ever.

The Act of 1890 allowed any local authority to provide accommodation for private patients, either conjoined to a rate-aided mental hospital, or separately. I believe that this is still the only separate hospital. Of those who supported the project at its inception, several had had personal experience of the difficulty in finding suitable accommodation for their own relatives, and had thus pressed for its acceptance.

One initial disability was that, being classed as a county hospital, we were unable to admit voluntary patients. This point was frequently discussed and debated, but we had to await the passing of the 1930 Act for the remedy of this very obvious defect.

The original intention was that the hospital should be self-supporting as regards maintenance only, leaving out of account the building and repairs and sinking fund. This was subsequently amended, and with the falling in of the sinking fund instalments we have been entirely self-supporting, and have been no charge upon the rates for many years. The rate of maintenance, at first thirty shillings a week, was raised from time to time, in consequence of increased cost of living, wages and overhead charges. It is now three guineas, although many are maintained below this figure.

The original building had 210 beds, but subsequent extension and the acquiring of other residences has raised the number to about 260. The ratio of our admissions to the number of beds available has always been high, and for the past three years has averaged 150 to the 240 beds occupied. The patients have been drawn from all classes—the better-paid artisans, the small shopkeeping and business community, and from a variety of the professions. The number of women has always been greater than the men—in the proportion

of three to two. This is because the men are still, in the majority of cases, the income earners and can maintain their wives, whereas the reverse is not possible. A survey of our present patients shows that 70% of the women and 60% of the men would have to go to our rate-supported hospitals if we closed our doors.

It may be mentioned that on opening, many patients whom we expected from other public hospitals in the West Riding did not come. This was because the distance, the cost of visiting and the time involved—which in many instances meant money—were the deciding factors. Now the ubiquity of the small car and facilities afforded by the motor bus have altered this.

Let us consider what are the advantages, apart from the obvious ones of more amenable surroundings and more individual care, that induce relatives to put themselves to considerable financial sacrifice to maintain a patient on a private basis.

The definition of a private patient is a negative one—it is that he is " not a pauper ".

For his certification a petitioner is required, and this is the private patient's greatest asset.

The petitioner has control. The knowledge that at any time this person, who has placed his relative in a hospital, can get him out again is comforting to the petitioner and beneficial to the patient, who can appreciate the fact.

This has always been known and stressed by hospital authorities, but even yet it is not sufficiently recognized by the general public. This has become more noticeable than ever since the advent of the voluntary patient.

Relatives coming to inquire as to the admission of a patient have frequently no prior knowledge of this, however, and, when they are made aware of their rights, there is much less reluctance to proceed to certification, if this should unfortunately become necessary. The low-rate patient seldom consults his solicitor on these matters.

Occasionally difficulties arise, and there have been discussions where the wrong person has acted as petitioner, as for example where the father has acted in the case of his daughter to the exclusion of his son-in-law. But such dissension is rare, and no barring certificate has been necessary here at any time since the opening of the hospital.

There are many occasions on which the petitioner desires to exercise the power of discharge in circumstances which you cannot altogether approve of because of the risks involved, but in every case some practical and safe solution of the problem can be found without recourse to the expedient of the barring certificate. It is not in these circumstances that accidents subsequently occur. With the coming of the voluntary system, 70% of the patients are now their own petitioners.

A review of the sources of income from which the low-rate patient meets the charges of his illness is instructive. In one-third of the cases this is derived

from trust funds. These have been left in most instances by near relatives, and the patient has generally a life interest only.

In about one-sixth it comes from personal savings or pensions—that is, the patient has, by his own energy and foresight, been able to provide for his breakdown.

This group includes certain war pensioners and others in Government or municipal employment, or some mutual benefit scheme.

In the other half of our admissions the charges have to be met out of the current family budget—from the earnings and savings of the small shopkeeper or business man—from the weekly wages or salary.

In the case of the small shopkeeper it would be a great advantage if the management and continuance of the business could be placed in the hands of the local county court or registrar. It is frequently of no value unless carried on. It could be so dealt with at small cost.

Mental illness is, without doubt, the most expensive form of disablement, and where prolonged, it is always more costly than any major operation, or serious physical illness.

Here the sum of over £900,000 for maintenance fees alone has been paid for approximately 4,000 patients—an average of over £200 per patient. Many of these have, of course, been custodial cases, and the cost must be amended correspondingly when recent and recoverable cases are alone considered.

There has been no choice of patients as regards severity, or acuteness of the illness. The only exception to this has been where the means of the patients are such as to make it unnecessary for them to come to us. The position is explained and they go elsewhere.

No extra charge as a rule is made for any special privilege, or for any extra attendance required in the acute stage. If the illness necessitates such, it is provided.

The charges must be known and fixed, since the family budget is to bear them. It will be seen that, from the economic aspect, a hospital of this kind can offer advantages that are outside the scope of most others.

Mental Disorders Among School Teachers.

I would now like to bring before you one occupational group that has interested me, and later lay before you some clinical types, the varying incidence of which reflects the changing circumstances of our times.

From the first, the large number of the teaching profession or those training for it was noted and became the subject of special attention. Altogether we have had 227 such admissions, of whom 177 were women and 50 men—that is, about 6% of our cases.

One reason for the smaller number of men has already been mentioned.

There are also fewer men teachers in comparison to women. Again, male teachers usually marry, which gives them a home life and wider interests outside their work, and they are not subject to the early change of life.

Who was the philosopher who said that "Woman has twice to make a success of her life, before and after the climacteric, man only once"?

We may assume that in a mental breakdown occurring after a certain age, the cause and type of the illness will not vary much from that occurring at a similar age in any other profession; that the breakdown is inherent in the man, rather than in his occupation.

Deducting these, and also some return cases, we have 133 women and only 36 men.

The first group of 41 cases was associated with the training period. Of these, 11 developed symptoms of schizophrenia after generally doing well in their early work and then showing an increased apathy and lack of interest in their later classes. Nine of these 11 had a strong and direct heredity for mental illness. In 5 of these 9 the effect of the heredity had been foreseen, and it had been thought advisable that the children should be trained for a career, as their prospects of marriage had been diminished by the parent's illness—a profound trauma to their children.

I have known this indirect effect of heredity, as it may be called, to occur in many other individuals.

In 10 cases the illness was directly due to overwork, brain-fag and exhaustion. No other factor was assignable. These cases came in listless, lethargic, confused, depressed, with hallucinations, and having, in 4 cases, attempted suicide.

In 7 of these—2 of whom had passed their examinations and had broken down before the results were known—complete recovery took place. They resumed their studies and, so far as I can trace, no subsequent breakdown has occurred.

Four died from the exhaustion of acute mania or confusion.

Of the remaining 17 the majority made more or less satisfactory improvement, but they had themselves recognized the inadvisability of going forward once more, or had been recommended not to do so.

In many cases the continued study, generally straight from school to college, had gradually revealed the fact that they had reached their capacity for learning before they had completed their course. The difficulty had been the old one of pouring a quart measure into a pint pot.

The next period, from the end of training to about 30, contained no fewer than 39 cases—a surprising number after the stress of training was over.

The younger members of this period seem to have found a difficulty in passing from the receptive to the more productive part of their lives—from being taught, to teaching. Shyness and a certain inability to maintain discipline caused several to look upon themselves as failures. There were many with psychic doubts and problems. Had they chosen the right career? Three

attempted to enter convent life, but broke down under the stress. No fewer than 8 developed the paranoid form of dementia præcox. One exciting cause in these two groups was given as the suicide of a girl friend in no fewer than 6 cases—in no case directly traceable to any overt homosexual factor; rather that the narrow training and probably close application to their work had lessened their opportunities of developing more heterosexual relationships. The cases about the climacteric period number 37, but by this time the causation is beginning to pass from their profession. The causes are almost equally psychic and physical. The work is getting on their nerves so that they cannot face a class (6 cases), the stress of living alone and doing their own domestic work (7 cases), family bereavement (9 cases). This frequently involves the conflict of giving up their career as against their duty to the surviving parent; the competition of younger staff; the increased responsibility of headship. Influenza was the exciting cause in 9 cases—aggravated by its epidemic character, resulting in several members of the staff being affected at the same time, and thus making release from duty difficult, or the necessary prolonged rest impossible.

Seven cases were associated with motor accidents—an increased reaction line from the commencement of illness contributing to the incidence.

Other physical causes were in many cases those of their years—tumour, heart disease, goitre, etc.

By the change of life, however, the patients were reaching an age when their breakdown allowances and pensions had become sufficient to maintain them in hospital, so that the figures given are probably fallacious.

Some Clinical Types.

One of the most noticeable changes has been in the incidence of general paralysis.

For some years we held the unenviable position of heading the percentage average in the returns of the Lunacy Commissioners.

At that time there was a large number of commercial representatives and agents going out from our large cities in Yorkshire, practically all over the world. There was a big export trade; the expenses allowed were liberal. Individuals with potential general paralysis, could and did continue their business activities. The initial illness was not a disabling one, and might even be overlooked by the man himself, and certainly could be concealed from his employer. Business men were thus able to carry on their work, and be efficient for years after the seeds of their illness had been sown. When, after fifteen or twenty years, a sudden seizure, or gradual deterioration, or carelessness in their work led to inquiry, their wealthy employers frequently, in recognition of their previous good service, paid for their hospital treatment and, because of

the comparatively short and definite course of the illness, continued to do so until the patient's death.

Prior to 1927 we had a total of 164 deaths in twenty-five years. The figures of the different lustra are so close that I have taken this as one period. This is equivalent to a yearly average of 3·25 deaths to each hundred resident.

In the past eleven years there have been only 4 deaths from this illness in all. Syphilis is being recognized earlier and more efficaciously treated, and if general paralysis subsequently develops, its treatment by malaria or otherwise is being undertaken in the municipal or general hospitals. So far as the low-rate patient is concerned, general paralysis is ceasing to be a mental hospital illness.

Alcoholism, on the other hand, has been almost negligible as a factor in our patients, and much below the average for the country. If the patient was employed, it was recognized at once and he lost his situation. If he was a small employer, he lost his business and he also was unable to come to us.

The cases of toxic hyperthyroidism have also changed entirely in their outlook and treatment. When I was first interested in these cases, the enlargement of the gland, the tachycardia and the exophthalmos were always noticeable, but the less obvious nervous and mental symptoms were overlooked, or ignored in many cases both by the general practitioner and by the consultant. This was particularly so in the early stages, where the physical were the leading symptoms. The mental mask of these thyrotoxic cases was not recognized.

Now it is interesting to record that Mr. Peter McEwan, of Bradford, who has operated on over 200 cases in the past two years, taking the common symptoms of the condition coming under his care in this part of Yorkshire, places the nervous and mental symptoms along with the rapidity of heart action, or auricular fibrillation, as being present in 100% of his cases. Now many of these cases, coming to us with these symptoms, are referred at once to the surgeon, and the prospect of treatment by surgical means is generally welcomed. The operation is, as a rule, very satisfactory. The scar, low down in the neck, is scarcely noticeable. We get a small proportion of these cases admitted during convalescence from the operation, where the system has not yet adjusted itself to the altered conditions following the removal of the greater portion of the gland; where the depression or suicidal thoughts, active before, are still continuing to colour their thoughts and conduct for a time. This is one of the illnesses where the subsequent treatment in the mental hospital is accepted at once as complementary to that of the general hospital.

On leaving, these patients have generally lost their apprehensions and dreads and are hopeful, and the final results are very satisfactory.

In diabetic cases, treatment by insulin has enabled many of the patients who formerly came to us for recurrent attacks of melancholia to be treated

at home, but we still have several cases whose variations require hospital treatment.

Formerly it was accepted as inevitable that, sooner or later, tuberculosis would become established in every mental hospital. Shortly after we opened, an old superintendent, when visiting, stated that in ten years at most tuberculosis in some form would be constantly present. We have been so far fortunate that it is many years since we had any case arising *de novo* in any patient or member of the staff, and at present we are free. This is a change that we now share with every hospital, and it is only mentioned lest the former prevalence of the disease in mental hospitals be forgotten.

Influenza sends in many cases, and is mentioned because there has been little change in its incidence. The group to which I wish to call attention and, for want of a better name, I have for many years called the "August Bank Holiday" type, has not changed. The initial attack of influenza takes place in the winter or early spring. This may vary from the mildest of symptoms to an illness of several days' duration with high temperature. There is listlessness, early fatigue, inability to concentrate, headaches and gradually increasing depression. The patients may return to business for short periods, but cannot continue. They become more and more irritable and exacting, and eventually there is a threat or attempt at suicide. Some are admitted before the holiday, when the family, worn out and exhausted, feel that they themselves want relief, and persuade the patient to place himself under care. The majority, however, come in when their own holiday has failed to help them and summer is passing.

There is generally some physical condition to treat—weak, irregular heart action, faulty elimination, or low blood-pressure—and the influenzal toxin having long ceased to act, the symptoms are entirely secondary physical and mechanical ones.

This group does better than would be expected, and the great majority are home before Christmas.

In the cases associated with involution there has also been change. There has been a diminution of the old-fashioned senile dotage. There has, however, been a very great increase in the pre-senile type.

The diminution in the former class in the low-rate patient began, I believe, with the coming of the Old Age Pension. Previous to that date old people, when no longer able to earn a livelihood, had perforce to live with one or other of their children. They were more or less an encumbrance and felt themselves to be so, and with their slow movements and lessened powers of adaptation, were generally thrust more or less in upon themselves. In this village alone no fewer than 18 old couples were enabled to carry on in houses of their own, with their own interests, in greater happiness with a valued independence, and less tendency to enfeeblement. They kept young longer.

Another factor, an economic one, is now gradually arising. With the smaller family there is not the same number of disengaged relatives to help in

any emergency. Very often, on inquiring into the possibility of such assistance, the reply is that there is no one who can be spared to help. The number of cases that could be discharged as "relieved" is now lessened by this absence of guardians from their own families.

The prognosis in many senile cases is quite comparable to the previous two decades.

The outlook is good where the onset of mental symptoms has followed any acute illness or infection, or has been due to any accident or mental shock—anything which occasions an alteration of blood-pressure.

Information on this point is often difficult to obtain, as already, when the symptoms become evident, the pressure has fallen. This must be raised and stimulation is the first requirement—strychnine, strophanthus, digitalis and some pituitary preparations are very useful. The raising of the blood-pressure is not without danger, but must be employed, the onset being frequently that of a sleepless, restless, chattering confusion, with mild impulse or tendency to wandering. The temptation has been to employ sedatives, but this should, if possible, be avoided. If a sedative be necessary, the safest and best is small doses of sulphonal.

In every case over 65 years of age we make it a routine practice to warn the relatives that the danger period is the third and fourth week after admission. In so many cases these symptoms are the precursors of a general break-up—an acute ante-mortem delirium. If this period is got over, these old people, who do not recover, seem to live on for ever, and form the bulk of our bedridden population.

The pre-senile cases were beginning to appear before the war in some numbers, but they are now much more frequent—the onset being generally from 55 to 60 years. Statistics from limited numbers are of little value, but in our records these cases are three times as frequent as before. They pass quickly through forgetfulness and a mild apathy and listlessness into a mindless dementia with complete amnesia. They become bedridden and die from exhaustion. They do not live long, and do not fill up the hospital beds. The course of their illness is very difficult to influence, or modify in any way.

Some General Changes.

The greatest change of all has been the vast increase of public interest in psychological matters since the war. This has undoubtedly been accompanied by the decline in the observance of any form of religion. Thirty years ago the reply to the question put to patients, as to what was their form of religion, was given at once—Church, Chapel, or Roman Catholic, as the case might be—with little hesitation and without explanation or apology. Mostly in the course of our inquiries we had already arrived at the correct conclusion without direct interrogation, from their answer and attitude to codes of

morals and conduct. Now, if we wish to know whether an individual is sociable or can meet his fellow man in company, our statements are directed to his reactions to the cinema, or his recreational pursuits.

For hundreds of years the people had looked to the Church for its standard of life, but man has to-day lost the beliefs of his fathers of the Middle Ages. Now man is looking round upon a world distracted and bewildered. The old standards are gone, or for the time have lost their values. The warm glow of faith has faded and mankind gropes in the darkness, seeking new gods on whom to lean.

In some countries reason and science have gone with the wind, and men find myopic comfort in " thinking with the blood ", or in putting a blind trust in megalomanic leaders.

In our democracy, where we still cling to our liberal institutions, we have no such emotional anchor, and we find the young men apprehensive that they may again be drawn into the vortex of war. They find a million citizens wanted for A.R.P. against fire and poison gas—new restrictions on the freedom of the individual—the outlook and development of the young confined by international barriers—the whole of the last war's aftermath of insecurity and lack of employment.

Even the boasted advance of science and mechanical technique all seem to be turning in one direction. Lord Weir, in his recent address to the International Engineers' Congress, stated :

> " No one is more conscious than the scientist and the engineer that to-day in many cases he is not directing the great sources of power in nature towards the use and convenience of man, but that he is having imposed on him a deflection of that duty leading to the destruction of our civilization."

The Archbishop of York, Dr. Temple, talking in Leeds about the outlook of young people to-day, says :

> " The fundamental thing is anxiety about the world and what is going to happen to it. A world in which they have extraordinarily little control over the forces that may entirely overthrow all their plans. Beneath the light-hearted surface of their lives there is often a profound unhappiness."

What wonder is it then that puzzled members of the younger generation are no longer looking outwards for their salvation, but are driven deep into their inmost consciousness for a solution of their problems and, finding there what does not give them peace, fly to the psychologist.

Many of the younger adolescents are finding some outlet for their emotions in the care of their bodies in the keep-fit movements, and others are turning to group movements to help them to a common interest and faith.

Man has turned to his own subjective processes, and any maladaptation of these leads to a feeling of illness, and that illness, being psychic, must be treated psychologically.

Unfortunately such treatment takes much time. One difficulty is that both doctor and patient must be tuned and in harmony for any good to be done. The family history, interests and environment have to become known and discussed, and it may be hours before you can reach that state of knowledge and mutual confidence in which advance and progress can be made.

In any mental hospital there is always work to be done. The most sympathetic of committees find this difficult to appreciate, but an increase of staffs seems inevitable.

In the treatment of any mental illness there must be a manifold approach to the patient, through his illness and infections, through his altered chemistry, through his endocrines, through his mechanical changes, through more purely psychological methods.

There is rarely a case in which the treatment cannot be directed to more than one aspect of it. It is not infrequently difficult to trace the primary and leading cause of the breakdown, and it is sometimes difficult to decide which is to be your first line of attack.

Drug treatment is still of great service and, with a good exponent, has benefits beyond the contents of the bottle.

To-morrow's discussions and papers will, I expect, lead to a further turn of the wheel, and drugs, given now by parenteral injection, will come into their own again—the beginning, we hope, of a fresh era in psychiatry.

There is no need to emphasize the great changes brought about by the Mental Treatment Act. Before it, our rate-provided hospitals were hedged round by many legal formalities and obstacles which made entrance a difficulty, and early treatment almost an impossibility. Now the voluntary and temporary patients form about three-quarters of our admissions. We have come into line with the ordinary hospital. It has also permitted our medical staffs to go out to meet their fellows in general hospitals in out-patient work and clinic.

The legal barriers, more rigid and confining than the melancholy grey walls of our old asylums, have at last been razed to permit both free ingress and egress. Our isolation is passing.

Many years ago Dr. Henry Maudsley—born and bred on the limestone not thirty miles from here—wrote at the end of his work, *The Pathology of Mind*, as follows :

> "A physician who had spent his life in ministering to diseased minds, might be excused if, asking himself at the end of it whether he had spent his life well, he accused the fortune of an evil hour which threw him on that track of work. He could not well help feeling something of bitterness in the certitude that one-half the disease he was treating never could get well, and something of misgiving in the reflection whether he had done real service to his kind in restoring the other half to reproductive work."

These sentences have always recurred to my mind when my advice has been asked by someone who is undecided about taking up our vocation, for already, when he has got so far, he can no longer resist the calling.

Surely Dr. Maudsley would not have been so pessimistic to-day. The great work of Sigmund Freud has cast a brilliant, if necessarily unequal light upon the dark places of psycho-pathology.

General paralysis would now appear to be largely under our control. Schizophrenia is being attacked with renewed hope since recent therapeutic knowledge and research have brought insulin and cardiazol and other agents to our aid.

Wider fields spread before the psychiatrist than ever before. In out-patient dispensaries, in child guidance clinics, in juvenile courts he finds an increasing welcome. Psychological factors in industry, in unemployment, in the ætiology of war invite his co-operation.

The outlook has certainly altered, and I envy the younger generation their opportunities.

Dr. Maudsley, however, omitted to mention one very important side of mental hospital work.

I recall one of my chiefs, the late Dr. Rutherford, of Dumfries, saying to me when I was dispirited :

> " Remember that when you are doing little apparent good to the patient, you are at least enabling his people to carry on. If they are satisfied that their relative is being well cared for and looked after, you are doing much. You allow the rest of the world to get about its work."

This is still true to-day.

Nearing the end of my ministry to diseased minds, and asking myself Maudsley's question as to whether I have spent my life well—I cannot say. But, if I could begin again with my present knowledge and experience, I would do so with deeper faith, with wider vision, and with greater hope.