He is survived by his daughter, Mrs. Droeser, and his son, Dr. Harold Savage, who is in practice in the Malay States.

By those who had been his colleagues he was always looked up to as a great master; he never lost interest in their careers, and many were the kindnesses to which those who worked with him can look back. He was always a ready adviser in troubles or difficulties. Many of his aphorisms remain in the memory, and his example of strenuous work and undying interest in his profession remains as a constant inspiration. Of him it may be truly said—"He being dead yet speaketh."

R. PERCY SMITH.

Part I.—Original Articles.

The Position of Psychological Medicine in Medical and Allied Services. The Presidential Address at the Annual Meeting of the Medico-Psychological Association of Great Britain and Ireland, held in London on July 11th–15th, 1921. By C. HUBERT BOND, *C.B.E.*, D.Sc., M.D.Edin., F.R.C.P.Lond., Commissioner of the Board of Control, and Emeritus Lecturer in Psychiatry at Middlesex Hospital Medical School.

PERMIT me at once to express my deep appreciation of the honour you have done me in electing me your President, and my particular satisfaction in finding myself inducted into this chair by a friend of many years' standing.

As to the wisdom of your choice I am still very doubtful, but the encouragement received from members of the Association, to whom those doubts have been fully communicated, and from my colleagues on the Board of Control, whose goodwill in the matter was essential, emboldens me to hope that my affection for our Association, now eighty years old, and the friendships gained during a close upon thirty years' membership, will in some measure obliterate deficiencies—be these through lack of time or capacity.

Charged with the preparation and delivery of an address, choice of subject must always be a matter of moment to the President-Elect, and, as the years roll on and the volume of addresses swells, the task of making a suitable selection becomes more formidable. Be their subject what it may—historical, analytical or synthetical—many of them have been scholarly and erudite, some of them landmarks, and all have been the fruit of expenditure of much time, and not infrequently of original observation and research. Nor is the task lightened when we yet have ringing in our ears the Maudsley Lecture—worthy of its orator—and when the address of the immediate Past-President was of the masterly

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and comprehensive character as that to which we listened from Dr. Menzies.

Though inclination led me to seek a clinical subject, there are valid reasons for offering you on this occasion an administrative topic, namely, "The Position of Psychological Medicine in Medical and Allied Services." The Great War, more than any other event since the birth of Christ, has fired men's imagination—the mightiest of levers. "Never again" was the vow constantly taken during the conflict's progress, coupled with an ardent belief in better times to come. In no department of science more than in medicine, especially in its preventive aspects, have these aspirations been higher, and in no branch of medicine has this revivifying influence and stimulant to interest—from within and on the part of the general public—been more potent than in our specialty, which in virtue of its inseparable medico-legal relationships must always demand administrative as well as medical consideration. But a sufficient stride forward was necessary to enable us to take stock of its lessons, to appraise the permanency of any change in incidence of mental maladies,[1] and to revise our demands—shaped in the first instance, and rightly so, on idealistic lines—in conformity with available resources.

Public Interest in Mental Disorders.

It would, indeed, be difficult to find anyone to-day who would assert that the mental health of the nation is of less moment to it than its physique: *orandum est, ut sit mens sana in corporo sano*, is as true to-day as when written eighteen hundred years ago, though by curtailment in quotation the words are apt to lose their real significance. Official recognition was given to this truism and to the kinship between mental and bodily disorders and their treatment, when by an Order in Council made on May 17th, 1920, the Board of Control became affiliated to the Ministry of Health, and most of the powers of the Secretary of State under the Lunacy and Deficiency Acts were transferred to the Minister of Health; and from this significant affiliation, which leaves the Lord

[1] *For example, while during the quinquennium* 1910–14 *the average number of female direct admissions into institutions for the insane and into single-care (in England and Wales) was* 11,668, *or a ratio of* 6·21 *per* 10,000 *population, the average number during the three war years,* 1915–17, *was* 10,894, *i.e., a ratio of* 5·59 *per* 10,000; *but the admissions during the years* 1918–20 *were* 11,687, 12,060 *and* 12,003 *respectively, with corresponding ratios of* 5·93, 6·15 *and* 6·07; *and it may be of some significance that, while in pre-war years there was no marked seasonal or monthly variation in the number of admissions, and such as obtained was never high in November, yet in* 1918, *while the number of female admissions in September and October were respectively* 7·2 *and* 7·8 *per cent. of the total female admissions during that year, the percentage during November was no less than* 10·1, *and the maximum number of reception orders made on any given day occurred on the day following the armistice. These figures, for what they are worth, have been restricted to females, because those relating to males would be vitiated by the large number of the male population serving with the Forces.*

Chancellor as the judicial head of lunacy administration in respect of matters of detention and property, it is legitimate to expect that, finding itself in the main stream of medical thought, psychological medicine will progress at least as rapidly as other branches of medicine. Last year also witnessed the appointment by the War Office—in accordance with a promise made to Parliament and as the outcome of the great public interest in the matter—of a departmental committee (presided over by Lord Southborough) to consider the different types of so-called "shell-shock," to collate and record for future use facts as to its nature, origin and treatment, and to advise whether some scientific method of guarding against its occurrence cannot be devised. In this connection we are looking forward to hearing a paper[1] by Dr. Bernard Hart. Moreover, of the numerous questions asked in both Houses of Parliament concerning persons under institutional treatment—whether general or in relation to specific cases—probably the majority relate to cases of mental or allied disorder. Owing to the implication of detention with treatment, these questions may quite possibly reflect not so much interest in therapy as suspicion or distrust of the *régime*, which it behoves us all to do our utmost to dispel; and for that purpose there are no better weapons than candour and the inducement of members of the public to come and see for themselves—in other words, minimise isolation. Nor, as a recent mark of the wide-spread interest in mental disorders, especially in the so-called borderland cases, should mention be omitted of the munificent foundation and endowment by Sir Ernest Cassel of a hospital with sixty beds for the treatment of functional nervous disorders of the type popularly designated as "nervous breakdown." For the objects of the institution, now known as the Cassel Hospital (Swaylands, Penshurst, Kent), the founder has devoted no less than £225,000.[2] Great good as well as further enlightenment as to the prevention and treatment of these illnesses may be safely anticipated from its operations, though probably they could be extended and carried out with less anxiety on to the selection of cases if legislation, on lines advocated by our Association and the Board of Control, could be secured. It is much to be hoped that this example of generosity will be followed by others, for while in former years donations and legacies to mental hospitals supported by voluntary contributions were frequent, during the last ten years or more they have been very rare; and it is lamentably notorious that there are now many persons of good education and social standing being treated in public mental hospitals at the cost of the ratepayers, because the institutions (thirteen in England), which were founded specially for such cases, but which were either not endowed at all, or (with perhaps one exception) only very

[1] "*The Problem of Prevention in the War Psychoneuroses.*"

[2] *See British Medical Journal, May 7th, 1921, p.* 680.

slenderly so, are not able to do anything like the charitable work they once did, and also for lack of funds most of them are unable to add the structural arrangements demanded for modern methods of treatment. This want should be made widely known, for these excellent hospitals have a fine record and are worthy of generous support.

To return, however, to the provision which should be made for psychological medicine within the scope of a general scheme such as that propounded by the Consultative Council of the Ministry of Health, valuable and well-considered suggestions to this end were made by Dr. Goodall in an article to which further reference will be made later.[1] They were reinforced by notes of cases illustrating the different arrangements for treatment which he set out, and, consistent with the terseness he used, it would be idle for me to attempt to deal with the matter afresh but for the fact that on these annual occasions brevity is not so rigidly enjoined; and if, in enlarging upon some of the points he made, some of his suggestions are repeated, he will acquit me, I hope, of plagiarism.

Existing Legal Restrictions on the Treatment of Mental Disorders.

There is still apparently so much misconception, not only in lay but even in professional circles, concerning the administrative problem involved when dealing with mental disorders, that, at the risk of being tedious, it seems advisable once again to set out the present legal position in sufficient detail to be clear, before endeavouring to show where are the deficiencies and what are the obstacles to progress.

Speaking generally, mental disorders and mental deficiency form the only department of medicine concerning which the English law lays down formalities of one kind or another which have to be complied with before the patient, except he continues to reside at home, can obtain treatment; and home—however good a one it may be—for many patients mentally ill is the worst possible place for their treatment.

(1) *Restrictions as to in-patient treatment.*—That is to say, a person who is sufficiently ill to enable him to be certified as of unsound mind within the meaning of the Lunacy Acts (England and Wales), but who is also sufficiently self-controlled and cognisant of his mental illness to enable him to seek treatment and to desire to be received for payment into a county or borough mental hospital, a general hospital, a nursing home, or into a private house—such a person cannot, without infringement of the law, be received until he has been duly certified as of unsound mind, and, with the exception of the brief (seven days) operation of urgency orders, until a justice's order has been obtained for not only his reception and retention, but for his detention too.

[1] *Lancet, September 11th*, 1920, *p.* 541.

(2) *Meagre extent to which voluntary treatment is permitted.*—As you well know, in the case of institutions for mental disorders other than the ninety-seven county or borough ones—namely, the thirteen registered hospitals and the fifty-eight licensed houses—such a person (as also a person who is fully *compos mentis* or else so slightly ill as to be not certifiable as of unsound mind) can be received and retained as a "voluntary boarder" on his personal application, and may leave upon giving twenty-four hours' notice in writing; that is to say, he may be detained against his will for twenty-four hours, but not longer, except in the meantime he is certified[1] and an order for detention is obtained. Notice of admission has in all cases to be sent to the Board of Control. In the case of the licensed houses, his application for reception (which requires to be in writing) has to be made—according to jurisdiction—either to the Commissioners or Justices, and the consent of a Commissioner or two Justices is necessary; but with respect to the registered hospitals, no consent or formalities of any kind are enjoined other than notice of his admission by the hospital to the Commissioners, who are thus able to institute such inquiry and exercise such supervision as may seem called for.

(3) *System of voluntary admission should be extended, especially to county and borough mental hospitals.*—The system of voluntary boarders in registered hospitals has worked well; and, judging by the remarkable and probably exceptional circumstance that, at the moment, of the number of cases admitted into the oldest of these hospitals, those received as voluntary boarders are as many as those admitted under certificates, the system finds favour. The explanation as to the difference between registered hospitals and licensed houses as respects stringency of requirements for voluntary admission s historical and accidental, and is not based on the respective merits of the two forms of institution: it would, indeed, be hard to find valid reason why the same simple and formless procedure should not be available for voluntary admission to licensed houses, and equally hard—except as to chargeability questions—with respect to county and borough mental hospitals, to which, as already stated, no voluntary admission is permitted.[2] As to this denial to public mental hospitals of what would

[1] *The Board of Control early in February, 1921, issued an important circular to medical superintendents of registered hospitals and licensed houses upon the admission of "voluntary boarders" to those institutions, and upon the question of the right course to adopt should such a patient develop symptoms rendering retention on a voluntary footing improper.*

[2] *The Maudsley Hospital, which is one of the County of London Mental Hospitals, is an exception to this statement; for in 1914-15 under Section 23 of the London County Council General Powers Act (5 and 6 George V), power was given for the reception and treatment of boarders and for the payment of their maintenance. The section is as follows: 23 (1) The Visiting Committee may, if they think fit, receive and lodge as a boarder and maintain and treat at the asylum known as the Maudsley Hospital on such terms and conditions as to payment and*

be an unquestionable boon to poorer persons who are mentally ill and desire treatment, it is useful to remember that in Scotland voluntary boarders are admissible to these institutions. After all, with regard to voluntary admissions, the really important factor from the point of view of the liberty of the subject is not the procedure leading up to admission, which, as the experience of at least thirty years in connection with registered hospitals shows, need only be of the simplest, but the subsequent inquiry and supervision. As to the authority which should undertake this work, it would not on an occasion such as this be proper to enter into a matter about which there has been controversy, even though it was based, as I believe, upon misunderstanding; but, in sometime re-considering the matter, the unchallenged and often repeated dictum of the Consultative Council—"that preventive and curative medicine cannot be separated on any sound principle, and must be brought together in close co-operation"—should be borne in mind.

It is therefore manifest that a person suffering from mental illness in degree sufficient for him to be certified as of unsound mind—no matter how speedily curable his illness is and no matter how desirous he is to be treated—cannot obtain treatment at all, as an in-patient for payment, in a public mental hospital, in a general hospital, nursing home or private house except fully certified and under an order for detention; that under considerable formalities he can secure it as a voluntary boarder in a licensed house; and that the least irksome restrictions under which he can get it are by his reception as a voluntary boarder into a registered hospital, for which all that is necessary is his bare application, which need not be in writing, though it practically always is so.

It is extraordinary how imperfectly these facts are grasped by medical practitioners, except those practising in the specialty; and it is therefore less surprising how almost totally ignorant of the scope of these legal restrictions are members of the general public. But, if we are ever to procure acceptable facilities for the prompt treatment of curable mental disorder in its incipient and early stages, it is of the utmost importance that at least the general effect of these provisions of the law should be understood.

(4) *No legal restrictions upon out-patient treatment.*—It is to be observed that these various restrictions apply solely to receiving, boarding, lodging or detaining, for payment, a person certifiable as of unsound mind—in short, and using a term more appropriate to a scheme

otherwise as they may determine any person suffering from incipient insanity or mental infirmity who is desirous of voluntarily submitting himself to treatment therefor. (2) *The Council or any Board of Guardians in the County may, if they think fit, defray the whole or any part of the expenses of the maintenance and treatment in the said asylum of any such person as a voluntary boarder.*

of medical services—solely to in-patients. There are no legal restrictions upon the treatment as an out-patient, either in the out-patient department of a general hospital or elsewhere, of such a person, however severe the symptoms may be. Elementary as this fact is, neither it, nor the great advantage to which it may be turned, seems to be at all adequately realised.

(5) *Dependence of legal restrictions upon "certifiability" and the difficulty of its definition.*—Similarly there are, of course, no lunacy law restrictions in relation to the treatment of a person nervously or mentally ill but who is not certifiable as of unsound mind. Doubtless that statement is open to the forsenic argument whether a person can be mentally ill and yet not be of "unsound mind," but to pursue it would carry us into difficult and deep waters, from which, even if we gave the time to navigate them, we should probably be stranded on a barren shore. The point to remember is that "certifiability," despite its intimate association with our profession, is a sociological rather than a medical term, which is elastic, and—as our revered Past-President, the late Dr. Mercier, never tired of telling us—is mainly dependent on conduct, the appraisement of which is made by medical practitioners largely in conformity with the community's feelings as to what manifestations of conduct justify deprivation of liberty; and those feelings in course of time are liable to change. In the early history of institutions for the insane, as their name connoted, their main function seems to have been as a refuge for those unable to fend for themselves, or whose conduct could not be tolerated by their families or the community; and, though the notion of recovery and treatment was never absent, safe custody was the key-note to much of the management. It is remarkable what little reference to "treatment" is to be found in the Lunacy Acts other than the use of the word in the form of documents for reception; but, with the advance of medical knowledge, treatment of the mental condition came more and more to the front, and still more recently the notion of prevention. With this advance in knowledge, therapeutic facilities in mental institutions have been greatly augmented, though many needs still await supply; and there are now numerous persons by whom or for whom treatment is sought, whose mental symptoms arouse at home nothing but an affectionate anxiety to have them effectively treated, and are either unknown to or do not trouble their neighbours. But if removal from home is advisable, at once arises the question, Is the patient certifiable? If clearly so, only under the provisions of the Lunacy Acts can he, as already explained, obtain treatment away from home as an in-patient. If apparently not so, those Acts purport complete freedom of choice as to where he is treated and an entire absence of any obstacles to treatment: such a description is, however, considerably wide of the truth.

(6) *Alleged "uncertifiability" too vague as a guide to arrangements.*—In the first place, we are confronted again with the impossibility of defining what degree of unsoundness of mind is certifiable, the influence of the personal equation, and the difficult position in which the family doctor finds himself in recommending certification against the wishes of the patient or relatives; and secondly, though the patient may be indubitably not certifiable, change of phase in mental affections—concerning which we are promised a paper[1] to-morrow by Dr. Beaton—is notoriously frequent, is apt to be startlingly sudden, and perhaps first manifested by suicidal impulse, but on the other hand may be insidious, and so be overlooked. These are some, though not all, of the pitfalls into which, until legislation gives some relief to the situation, a person, who "for payment takes charge of, receives to board or lodge"[2] one of these nervously or mentally ill or so-called borderland cases, may be led; and, as the fall is a misdemeanour—and one in which absence of guilty knowledge cannot be pleaded as a defence—carrying with it a penalty not exceeding £50, there is naturally no small apprehension and reluctance in undertaking to provide accommodation for such cases, either in private houses or in general or special nursing homes.

If a brief digression may be permitted, it is my desire to take this opportunity to interpolate two remarks: one of regret at the imperfect appreciation of these facts by so many members of our profession, and their habit, when asked for a report on a person alleged to be certifiably of unsound mind, of replying that they do not consider certification necessary, which is an evasion, intentional or accidental, of the question, and is not a matter they are entitled to decide; and one by way of protest at the readiness with which some, including members of our own specialty, will profess an opinion of uncertifiability in the face of prominent symptoms of insanity or mental deficiency, and—what is worse—will recommend the case to the charge of someone ignorant of the law, who in good faith accepts the case on the strength of the recommendation but who is not protected thereby. The dilemma of the doctor, who is anxious to secure treatment for the patient, but who is met with positive refusal by the relatives to assent to certification, is patent; but he would render a far greater service to psychological medicine were he less complacent and were he to do more to create a better understanding of the need of legislation upon this matter.

The position as to cases alleged to be uncertifiable can be summed up by saying that, while it is undoubtedly true there are no Lunacy Law restrictions upon the arrangement of whatever medical services may be accepted as desirable for uncertifiable cases; in point of fact, owing to well-grounded apprehension in the matter, there is a lamentable

[1] *"Change of Phase in the Psychoses," by Thomas Beaton.*

[2] *Section 315 of the Lunacy Act.*

deficiency of such arrangements, and consequently there are many--we may safely say thousands—for whom no such medical services have hitherto been available; nor will they be fully provided until legislation is secured. It was therefore so far satisfactory to see introduced into the Ministry of Health (Miscellaneous Provisions) Bill, two sections (8 and 9 of the draft of December 9th, 1920), which, had they become law, would have in some measure met these difficulties in respect of mental disorder incipient in character and of recent origin; but they did not purport to provide for voluntary admission into county and borough mental hospitals,[1] and under formalities somewhat stricter than those which now obtain under the Lunacy Acts for voluntary boarders in registered hospitals and licensed houses, they were definitely limited to voluntary admission.

(7) *Certifiable cases, either* (a) *without volition or* (b) *hostile to treatment.*—This limitation to voluntary admissions brings us to the remaining two groups in the administrative classification, under which mental cases can be conveniently considered in respect of medical services required for them. All the cases in the two groups now to be considered are indubitably certifiable as of unsound mind. But there is this marked difference between them: in the one group (*a*), whether the mental illness is recent or of long standing, all are either too severely ill to realise their surroundings and understand what arrangements are made for their treatment—just as not infrequently happens in infectious cases who are removed neither with nor against their consent to an isolation hospital—or are so severely ill or decayed mentally that, though not unconscious of their surroundings, they are nevertheless without volition, and tacitly acquiesce in what steps are taken for their treatment, or at any rate raise no objection thereto; in the other group (*b*), again whether the mental illness is recent or of long standing, they are fully cognisant, though perhaps deluded, as to their surroundings, but do not believe or will not own that they are mentally ill, and they resent direction or control or any suggestion of in-patient treatment. On behalf of any of the cases in this latter (group the "unwilling" cases, as they may briefly be termed), no one who has seriously thought the matter out suggests any relaxation or change in the law; and there is common consent that, even though the patient is free from propensity dangerous to himself and others, no attempt ought to be made to secure his control for purposes of treatment except under the provisions of the Lunacy Acts. In the former group—namely, where there is absence of volition—are included a large proportion of the long-standing, chronic cases which go to

[1] *Neither did they as respects voluntary admission into registered hospitals and licensed houses; but this was immaterial in view of the fact that both these classes of institution can already receive voluntary boarders.*

make up the accumulated residue of the inmates of institutions for the insane. Here, again, no one suggests that any of them should be dealt with other than under the Lunacy Acts, or that any of the provisions in those Acts should be relaxed in their favour. If on no other grounds—and there are many—questions of authority to deal with such a patient's property would arise.

(8) *Considerations affecting "recent" certifiable cases, without volition.*—Facts worthy of altogether different consideration can, however, be given as to recent cases with impaired volition—the "indifferent" as, in contrast with the "unwilling" cases, they may be termed. In their early stages, they—together with those capable, if permitted, of voluntarily submitting themselves to in-patient treatment (the "willing")—are the source of by far the majority of recoveries from an attack of mental disorder; and for the purposes of our argument, it is of importance to remember that most of these recoveries take place within a comparatively few months of the reputed onset of the mental illness. Thus, of 700 recoveries which were made in patients under the care of colleagues and myself at Long-Grove Mental Hospital (in the years 1907–11), 44 *per cent.*, took place within six months of the commencement of the particular attack of mental disorder, 60 *per cent.* within nine months and 73 *per cent.* within a year, and these percentages would be appreciably higher were they based—as would be quite fair—upon the duration of residence within the hospital. There is also no reason to suppose that they would be less were a corresponding estimate available from totals for the whole country. The extent of the problem, with its hardship so often pointed out, and the degree to which its solution might conceivably affect "the liberty of the subject," can be gauged by remembering that—taking the population of England and Wales at about 35 millions, or, allowing for the rarity of insanity under fifteen years of age and deducting persons below that age, at 24 millions, and relying on pre-war figures—some 22,000 persons are yearly certified and sent to institutions for the insane, *i.e.*, 1 in 1,600, or disregarding childhood, 1 in 1,100 of the general population; and that, of those 22,000, nearly 8,000, or about 35 *per cent.*, recover. Moreover, of those 22,000, 86 *per cent.* are admitted into county and borough mental hospitals, so that, for the "willing," the system of voluntary admission into the registered hospitals and licensed houses is but little available.[1]

There are no reliable figures which can be quoted by way of indicating the proportions in which the "willing," the "indifferent" and the "unwilling" are distributed among the 22,000—a deficiency which, had it been possible to find the time, it was my hope to have supplied.

[1] *During the year* 1920, *besides* 609 *direct admissions under certificates into registered hospitals and* 1,037 *into licensed houses, there were* 325 *voluntary boarders received into the former and* 308 *into the latter.*

The point is obviously not without importance, and endeavour shall yet be made to make an estimate based on personal knowledge of a large number of cases; but the value of such an estimate would be enhanced did it convey the views of several of us who possess the data necessary for analysis. May I therefore express the hope that others besides myself will take up the point, so that the Association can, if asked, express a reliable opinion on it.

Assuming—and it is probably safe to do so—that by far the majority of these yearly 22,000 direct admissions would fall into the two categories I have designated as the "willing" and the "indifferent," where, then, is the good sense or fairness—especially if they themselves or their relatives resent the procedure—in insisting that they shall all go through the formalities of certification, involving the recording of their names and other family information in a name-register of approximately 100,000 cases of insanity, the great majority of which are of the chronic type, and in insisting that a Justice's order shall be obtained to compel them to do that which they themselves desire or proffer no objection to do? Is it not reasonable to press, on their behalf, for such a relaxation of the law as will enable treatment, without certification, to be carried out for a limited period and under adequate supervision?

So far as known to me, the only opposition to the relief from this situation, suggested in reports of this Association and in those of the Board of Control and of others, comes from persons who regard the Lunacy Act as one of the sacrosanct charters, any amendment of which might expose persons of sound mind to an assault on their liberty. They do not realise that if there is nowadays ground for the slightest such apprehension—and it is worth remembering that, in the days of the Select Committee on Lunacy Law which sat in 1877–8 and is sometimes referred to as the Dillwyn Committee, in not one of the many such allegations investigated was *mala-fides* or other sinister motive proved—the actual procedure of the Lunacy Acts is on the whole a greater source of protection to the authorities of the institution than to the detained person. The latter's surest safeguards provided by these Acts are his right of correspondence and, as the Committee reported, the frequent and careful visitation of the institutions, and full power[1] placed in the hands of Commissioners to order his discharge.

Candour and full explanation count for much in a matter that is in any way controversial. It is therefore only fair to point out that a case which can clearly be labelled "indifferent" may, during in-patient treatment, emerge and pass into a condition of unwillingness. To any such objection the reply is that the relief which has been proposed does not carry with it any power whatsoever of retention against the

[1] *Such power is possessed by the Commissioners now as respects patients of the private class, but not as respects patients paid for out of the rates except by the indirect means mentioned in the foot-note on p.* 416.

patient's will; and furthermore, those who are ready to assent to relaxation of the law in favour of voluntary admission (the "willing" cases) but object to extend the concession to the "indifferent," may fairly be reminded of the fact that a "willing" case, quite as readily as one of the "indifferent" ones, may pass into a phase of hostility and unwillingness.

(9) *Extent to which notification, in lieu of certification, might be requisite.*—The truth is that against possible unauthorised detention, whether for personal profit or—as is much more likely—for the sake of carrying on treatment, the real protection, apart from the ordinary common-law remedies, is not in forms and procedure, but in supervision (facility for inquiry and visitation) and power to take such action as seems called for, at the hands of those who have the requisite experience and independence. This raises the question of what is desirable in the way of notification. The recommendations of this Association[1] contemplated that buildings to be used for mental in-patient clinics (the urgent need for which remains unsatisfied), whether as annexes to general hospitals or as special units provided by local authorities, would be subject to some inspection and approval, but made no mention as to whether names of patients should be notified on admission and departure[2]; presumably such was not considered necessary in view of the absence of power of detention and the public status of these clinics—and this, too, was the opinion of the Board of Control. But, with respect to the advocated further provision for private patients and residential treatment for profit, the Association recommended that the fact of the patient's reception and of his cessation of residence should be intimated (presumably *nominatim*) to the Board of Control. The latter were prepared to dispense with knowledge of the patient's name, relying on the power which they assumed would be given them to make inquiry and to visit when the circumstances of the case called for such action, and believing that the satisfaction of patients and their relatives and the general success of the proposals would be promoted in proportion to the minimum of notification, publicity and procedure, compatible with safety. It is a point of principle which may need further consideration whenever—or preferably before—fresh legislation upon the matter is introduced.

Need of Further Propaganda.

So many of you are fully conversant with these medico-legal matters, and have been stout advocates of the measures of relief indicated, that some apology should be made for dealing with them at a length that

[1] *Passed at the Quarterly Meeting, November 26th*, 1918; *see pp.* 36–44, *Journal of Mental Science, January*, 1919.
[2] *Ibid., Recommendations 2 to* 8 *and* 12.

may seem out of place and to savour of the conversion of the converted; especially some is perhaps due to those of my Scottish *confrères*, who believe that their lunacy enactments have been freed from these impediments to early treatment. If excuse is needed, it is my belief that the reason the sections in the Bill, to which allusion has been made, were limited to cases capable of exercising full volition, was not on account of any disbelief in the rectitude of a wider measure of relief, but because those in the best position to know had strong grounds for doubting whether anything going beyond that tabled could be passed into law. If that view is correct it surely behoves members of the Association individually to use the pause imposed by the public's financial restrictions, before re-opening this subject, in converting that opposed body of opinion to our way of thinking—not forgetting that we are regarded as biased, and rightly so; for we *are* biased, but only in the interests of the patients we are called upon to treat and the many others that are left without treatment. To this end, are you satisfied that individual members of your Visiting Committees are sufficiently seised of the details of our proposals and of their reasons to enable them, in conjunction with yourselves, to take occasion to discuss and urge them upon their respective members of Parliament? Have you examples ready with which to illustrate your points? Two come at once to mind, and they have been cited before: first, the position of sailors and soldiers, to whom, because they are service men, the restrictions of the Lunacy Acts are regarded as not necessarily applicable, thus enabling them, if mentally ill, to be treated without the intervention of a justice—yet it would be less difficult than under our proposals, in which detention is ruled out, to conjure up conceivable abuses which have neither occurred nor been alleged; and second, the position of a woman who soon after childbirth develops mental illness, which our experience teaches us—at any rate as regards the particular attack, stormy, delirious and life-endangering though it may be—is usually eminently curable. Treatment at home, save under the most favourable circumstances, is out of the question; and, to obtain the requisite in-patient treatment, a detention order must be obtained: furthermore, if the case is sent to a public mental hospital other than as a private patient, her discharge, on abatement of the symptoms and notwithstanding her admission was probably initiated by the husband, cannot be claimed either by the patient or her husband, but requires an order of the Visiting Committee.[1] Is not this a travesty of liberty, a despotism raised out of a will-o'-the-wisp abstraction, and a double outrage, for mother and infant, equally helpless, are both involved? The cry, "O! liberté! que de crimes on commêt dans ton nom!" truly needs not the guillotine for its utterance.

[1] *This statement is substantially true, but the effect of Sect. 49 of the 1890 Lunacy Act provides, though in a somewhat cumbrous fashion, a mode of intervention by the Commissioners.*

It has occasionally been my province to discuss these matters with those who are firmly opposed to the slightest relaxation in the lunacy law. My experience on more than one occasion has been that the accuracy of my statement as to the law has been at once challenged, and this contention was reinforced by the citation of the case of a near relative acutely mentally ill, who, under medical advice and direction and to the complete satisfaction of my contender, was being treated without certification or other objectionable formalities in a nursing home. All was well in his eyes: certification had been mentioned to him, but he would under no circumstances have consented to it; the patient was not in a condition to object, and he himself had full confidence in the steps being taken for treatment, so where was the necessity of her certification? and so forth. But, on its ultimately being brought home to him that his relative was in illegal charge and that the person in charge, if he cared to give me the name and address, could and probably would be prosecuted, his conversion was instant, and was proclaimed by the vehemence of his remark, "Then the law ought to be altered." Nor was the opportunity lost to explain further to him that, if the much-to-be-desired alteration had been in force, his relative could not only have been treated where he desired without contravention of the law, but her case would have received that independent supervision which centuries of experience shows is necessary if the care of mental cases is to be kept free from abuses; and furthermore, that the nature of the supervision need not include demand for knowledge of the patient's name, save in the event of something seriously unsatisfactory in the arrangements being apparent. As individuals it is only occasionally that opportunity of such propaganda work presents itself to us; but, if each member does his share the collective influence of the Association can indeed be great, and, except we bestir ourselves and help those who are willing to see the desired measure of relief granted, the medical treatment of incipient mental disorder is in risk of remaining indefinitely in shackles. It is worth remembering that during the years—particularly the last decade—we have been arguing the matter in this country, the measures we advocate have been put into operation in the Union of South Africa in a consolidating enactment, entitled the Mental Disorders Act of 1916, upon which those responsible for it may be warmly congratulated, and concerning which we are to learn something in the course of this meeting from their Commissioner in Mental Disorders (Dr. J. T. Dunston), whom we are glad to welcome back among us. If a single criticism of it is not out of place, exception may be taken to the limit of fifty days—which is much too brief for effective treatment—during which the patient can be retained uncertified, and which contrasts unfavourably with our projected period of at least six months.

Suggestions, though Comprehensive, must have Regard to existing Financial Conditions.

The lengthy manner in which have been set out the legal difficulties of our present position and the way in which they obstruct progress in psychological medicine, tedious though I fear its exposition has been, enables suggestions to be made as to what are the needs of our specialty in any scheme of medical services much more concisely than would otherwise have been possible, and renders it possible to point out what can be accomplished forthwith and what has to await the Legislature's goodwill. But as to immediate possibilities, if we are to gain a hearing and not be regarded as visionaries, it must be apparent that during this period of straitened finance, our administrative proposals must be strictly confined to such as involve neither capital expenditure nor increase in cost of maintenance other than that which can truthfully be said to be essential for treatment; and the possibility of even the latter may be doubtful, if redoubled efforts to economise in other directions are not made. That common-sensed policy, imposed by the rigour of circumstances, need not, however, debar us from including in our perspective facilities admittedly costly, to be provided when money is available, and which we believe requisite, as well for medical education as for treatment—preventive and curative: without their mention we might indeed fail to be understood.

The Report of the Consultative Council on Medical and Allied Services.

Our country's history bespeaks our innate preference to develop existing structures rather than build upon a *tabula rasa*, a preference consistently shown in the interim report of the Consultative Council on Medical and Allied Services, established under the Ministry of Health Act of 1919. This report was issued in May, 1920, and corresponding ones have been made by the Welsh Consultative Council, by the Consultative Council of the Scottish Board of Health, and by the Irish Public Health Council. With these highly interesting and important communications, time compels me to assume considerable familiarity on your part, but their contents will well repay your close perusal, if they have not already had it,[1] and a useful summary of the one first mentioned, together with many illuminating questions and answers arising therefrom, can be consulted in the *British Medical Journal*.[2]

The title of my remarks has been purposely directed to these reports because, firstly, there is obvious advantage in having a scheme which

[1] *Each is obtainable at H.M. Stationery Office in London, Cardiff, Edinburgh and Dublin.*

[2] *Pp.* 151–5 *of the Supplement to the British Medical Journal, April* 30*th*, 1921.

has been shaped by highly competent hands largely out of existing structures, and which therefore—whether it matures soon or late, and with or without modifications—affords a reasonably secure basis on which we can formulate suggestions to meet any special facilities demanded for preventive, curative and custodial treatment of mental and allied disorders; and secondly, as has been elsewhere remarked, only brief and occasional reference to these disorders is made in the reports.

(1) References to Psychological Medicine in the Council's Reports.

The Irish Report takes full cognisance of institutions for the insane, and specific reference is made in it to recommendations conveyed by a deputation from the Irish Division of the Medico-Psychological Association, but as the Council, set up to formulate proposals to be embodied in an Irish Public Health Bill, have included in their recommendations the establishment of a national medical service for Ireland, from which would be provided the medical staffs of mental hospitals—a proposal which finds no counterpart in the reports from the other portions of the United Kingdom—and as no Ministry of Health has yet been established there, it would be premature for my present purpose to make more than this passing allusion to it, full of interest though it is.

The **Consultative Council of the Scottish Board of Health** included among its members our President-Elect, Prof. George M. Robertson; therefore, although specific reference to mental illness is confined in their report to a paragraph[1] advocating preventive or rest homes for those suffering from over-strain or threatening illness, physical or mental, we may be sure that the matter did not escape attention, and it has to be remembered further that the provision of hospital accommodation, together with its place in relation to the medical service of the nation, was specially referred to a joint committee which had not then reported.

The **Welsh Report** and the reports made to the Council by its committees for typical areas contain several allusions to existing and future provision for mental cases: (i) *The committee appointed to consider the arrangements required for an area both industrial and urban (with a population of* 100,000), expressed the opinion that the existing general hospital (at Aberdare) could be expanded and adapted as the principal local centre of the area, and, among the eight departments (each to be capable of future extension) which they advised should be comprised in this centre, was one described as "various clinics, *e.g.*, dental, tuberculous, venereal, pediatric, *psychatric*, etc." The point is not quite clear, but the context suggests that beds are not contemplated in the psychiatric clinic; nor, although mention is made of an existing open-air school with 140 children (mental and physical defectives) on the roll, is it stated, in the description of existing and future institutional accommodation, where mental cases are now or should in future be treated, except for a general statement that the main central institutions in Cardiff would be available for cases of special character. (ii) *The committee, appointed to consider arrangements for a mixed industrial and rural area (East Carmarthen, with a population of* 100,000), included within their purview of available institutions the county hospital and the mental hospital at Carmarthen, neither of which, as they pointed out, is actually within the area, and they stated that the latter, though very full and serving the three counties of Carmarthen, Cardigan and Pembroke, may be regarded as providing the necessary facilities. In recommending the provision of a central institute (at Llanelly) arranged in two parts—one centralised in the town and comprising various clinics and the out-patient department, and the other, consisting of the main hospital, laboratories, etc., some distance away from the centre, and on a site of about fifteen acres—the provision of a *psychiatric clinic* at the centre is stated to be desirable; whether such clinic implies bed accommodation again is not clear. It is added that cases requiring

[1] *Para. 27 (c) on p. 16 of the Report.*

further treatment would be drafted to the main hospital, except cases of tuberculosis and mental disorder, the latter to be sent to the county mental hospital at Carmarthen. The committee also expressed the opinion that Swansea should be regarded (as at present) as the centre for a large and fully-equipped institution to serve this East Carmarthen area for all cases requiring, from their unusual nature, special treatment. In this connection, and as the committee were empowered to disregard existing local government boundaries, a note of surprise is perhaps permissible that, in their new health scheme, no inclusion is made of the mental hospital for 600 beds which was in course of erection for the county borough of Swansea and Merthyr Tydvil, and which, it may be assumed, will ultimately be completed. No allusion is made to provision for cases of mental deficiency. (iii) *The Rural and Semi-Urban Areas Committee*, in selecting the mountainous county of Merioneth, with a population of 45,500, as a type, point out that the only existing hospital in the area is a small local one (eight beds), maintained by the owners of certain quarries for the treatment of accidents, the quarrymen themselves also contributing out of their wages towards the cost of the operations. The opinion was formed that such an area does not lend itself to the provision for its own purposes of a central hospital institution, and the committee was driven to the conclusion that, for the provision of central (major) institutions, it would be advisable to regard at least the whole of North Wales as a single area. It is of interest to us to note that on this assumption they recommended, besides the provision of three general hospitals, a tuberculosis sanatorium and an adequate number of convalescent and rest homes; that a *mental hospital*, with beds for 1,000 patients, and an *institution for mental defectives*, with at least 300 to 400 beds, should be available and conveniently accessible from all parts of North Wales; they further recommended adequate and separate provision for *epileptics*. They made no specific reference to the mental hospital at Denbigh, which, with its 1,000 beds, is already available for North Wales.[1] In considering the needs for local institutions within the area (Merioneth), they thought that two or three might be necessary, but that, if suitably placed, they might also serve contiguous areas, and, in outlining their accommodation, they included, besides beds for general and maternity cases, a variety of clinics, among which is mentioned *a clinic for mental cases*.

The **Report of the Consultative Council in reference to England** made reference to mental diseases (and epilepsy) only in their paragraphs relating to supplementary services,[2] amongst which are mentioned "hospitals for curable and incurable mental disease," "institutions for the feeble-minded" and "epileptic colonies." In a timely paper in the *Lancet*,[3] Dr. Edwin Goodall drew attention to this point, and emphasised it by saying: "Incurable mental disease could be adequately provided for thus, but not curable. The psychoses and psychoneuroses together contribute a vast and oppressive liability, which, I maintain, cannot be discharged through the medium of a mere supplementary service. They were long since shunted on to the sidings of the main traffic of disease, where they have remained, mainly stationary. They, with their medical and nursing services, have long suffered, and still suffer, all the evils of segregation." Doubtless we should have liked to see them specified at least with the nine special services enumerated under the equipment scheduled as appertaining to the proposed secondary health centres. It is, however, within my knowledge that the reason why the requirements for dealing with mental and allied disorders—especially from the preventative and curative aspect—were not more elaborated, was not lack of appreciation of the importance of the matter, but rather the complexity of the problem, adequate solution of which still awaits legislation.

(2) Outline of Consultative Council's Scheme.

The report of the Consultative Council formulates a scheme for the supply of medical and allied service which has as its pivot the work

[1] *That is, for the counties of Denbigh, Flint, Carnarvon, Anglesea and Merioneth.*

[2] *Paras. 14 and 74, pp. 6 and 15 and the summary on p. 25.*

[3] *Lancet, September 11th, 1920, p. 541.*

of the general practitioner, maintains the voluntary hospitals as an essential part of the scheme, and emphasises the inseparability of preventative and curative medicine. Its framework, as regards each area into which the country would be divided, is a constellated system of health centres of three magnitudes—the teaching hospital with its medical school at the hub, secondary health centres and primary health centres; and along the links between a constellation of primary centres and their secondary centre, and between two or more of the latter and the teaching centre, activity would be both centripetal and centrifugal. Services especially for patients requiring institutional treatment of specialised kinds (among which are included mental hospitals, institutions for mental defectives and colonies for epileptics) are mentioned as correlated to both primary and secondary health centres, and are designated "supplementary services." Doubtless direct correlation between supplementary services (centres) and the university centre (teaching hospital and medical school) is not intentionally excluded; it is, at any rate, a need which many of us feel and have urged with respect to mental institutions. For purposes of local co-ordination, and to give effect to unity of idea and purpose by securing reciprocal communication between the associated centres, the erection of a new type of health authority is postulated, upon which the medical profession would be effectively represented and associated, with which would also be a local medical advisory council. Complete co-ordination between the various areas would be effected within the Ministry of Health.

The vista such a scheme opens out is an appealing one and incites to be up and doing. Let us, therefore, set down what services (treatment facilities) our sphere of work can at the moment offer for inclusion in such a scheme, what services are needed to complete our share—pointing out those which can be arranged without expenditure of money, the points in the Council's scheme at which our sphere impinges, and what arrangements at each point are needed for its inclusion.

(3) Projected Local Health Authority.

The projected local health authority itself demands some notice; for it has to be remembered that—apart from the fact that certain institutions, organised as permanent units for cases of mental disorder and mental deficiency and others more or less temporarily so organised, are under the Poor-Law authorities—the managing bodies of public institutions for the insane and mental defectives are the statutory committees of county and borough councils; and that, if it is desired to secure effective representation on them of the medical profession, it

would be necessary to co-opt medical practitioners upon them. Co-option is not provided for in the Lunacy Acts, but it is in the Mental Deficiency Act, which also enables the Mental Deficiency Committee to be appointed, subject to the consent of the Minister of Health, as the statutory Asylum (Mental Hospital) Committee; and this, indeed, seems to be the way out of any difficulty in arranging for these institutions to come under a health authority constituted on the lines suggested in the report.

(4) Domiciliary Service.

(i) *Relation of general practitioners to psychological medicine.*—Domiciliary service is defined as the first element in the scheme, and as comprising the services of the doctor, dentist, pharmacist, nurse, midwife, and health visitor. Its consideration for our purposes at once raises the question of the relationship of the private practitioner (general or specialist) to psychological medicine—a difficult, but most important matter. The certification of cases under the Lunacy and Mental Deficiency Acts is one of the now many duties which all medical practitioners are liable under statute to have to perform. An enumeration of them is to be found in Sir George Newman's interesting contribution to the discussion which took place last year at Cambridge on the future of medical practice.[1] But with respect to the actual treatment of mental disorders, domiciliary service, as rendered by medical practitioners in their surgeries, consulting-rooms, and in the homes of the families they attend, is almost entirely confined to patients in well-to-do circumstances, and is in the hands of almost none but specialists. Most general practitioners seem to regard mental disorders so much as an exotic in general medicine that, frankly owning their lack of experience in their treatment, they are only too willing it should be taken in hand by others. This is a great misfortune, for, while my sympathies are more with their attitude than with the "therapeutic nihilism" of those who accept the post of medical attendant to patients in single care and in urgent need of active mental treatment, but who confine their ministrations chiefly to attention to the patients' general health, it is my strong conviction that the general practitioner could, under suitable arrangements, be of the greatest possible service to the cause of psychological medicine. It is he alone who, while in attendance on one member of the family, has the opportunity of observing with a trained eye other members regarded as bodily and mentally sound, but in whom he, however, recognises interesting traits and temperamental peculiarities. Were he encouraged to be systematic in such observations and to adopt some method of recording them, they would be of inestimable value in collecting reliable data for that which

[1] *See British Medical Journal, July 10th, 1920, pp. 33-36.*

in our work might well be called the "research magnificent"—in other words, a knowledge of the prolegomena and earliest stages of mental disorder. Whether in "nativity, chance or dearth," it is he more than anyone else—not even excepting the priest—whose profession brings him into the most intimate and confidential social life of the people, both communally and in the family. It is he who, preferably in conjunction with the "health visitor," might be able to give us many a hint which, by putting the specialist on the track of events and troubles—those *res angusta domi* apparently insignificant at the time and forgotten by the patient—which would be invaluable in the application of psychotherapy; of not less, and perhaps of still more importance, it is he who can tell us of the temperament, mental make-up and behaviour of those members of the household under whose influence the patient has been in early childhood. The importance of this last item—as to which Dr. Mapother[1] will give us some illustrations—is continually being thrust upon me, and, firm believer as I of course am in the operation of heredity, I am inclined to place the influence of irresistible imitation (*ex infectione*, as it were) certainly not less high than that of heredity. Many a neurotic and mentally affected patient is said to have inherited his morbid make-up when in reality he was "infected" with it; and verily there is a romance of personality as well as its birth.

Heredity.

Heredity, in my opinion, has been dressed far too much as a bogey, especially in relation to mental disorders; and while its malign influence is a favourite topic for charts and statistics, perhaps accurate enough as far as they go, how rarely are we shown the obverse, with its reminder to "weigh our sorrow with our comfort." So axiomatic has its relation to mental disorders become that many persons, because it happens they have had in their family more than its share of cases of mental breakdown, live their lives in terror, and in obedience to a spectre, a veritable *hereditas damnosa*, they distort them accordingly; whereas, had they taken their skeleton out of its cupboard, and discussed it freely with a physician who does not regard all mental disorders and deficiency as a mass of homogeneous insanity, they might have been vastly comforted; indeed, cases have come under my notice in which, when the much-feared breakdown does occur, the long-endured dread has seemed to me to have itself been the principal agent—"mad from life's history" might well be said. In my judgment, our knowledge of the laws of hereditable mental and nervous phenomena is too slender to warrant advocacy either of segregation or of surgical interference solely on the score of betterment of the next generation, and the only safe guide in this relation is a consideration of the ability of the subject to perform the duties of parenthood.[2]

(ii) *Influence of the general practitioner in promoting mental hygiene.*—But to revert to the *rôle* of domiciliary service: it cannot be overlooked that in many cases of active mental disorder removal from home, either

[1] "*Phantasies of Childhood and Adolescence as a Source of Delusions*," *by Edward Mapother.*

[2] *See Section "Insanity in Association with Child-bearing," by C. H. Bond, in Berkeley and Bonney's "Difficulties and Emergencies of Obstetric Practice," 1st ed., p.* 113.

to single care or to an institution, has been accepted as an essential preliminary to successful treatment. In the light of what it is proposed to say as to primary centres, this hitherto cardinal principle may admit of some modification, but so far as it holds good, it manifestly limits domiciliary service considerably. Hitherto the general practitioner has not been in a position to do much in the way of mental treatment, owing firstly—as he would himself be the first to say—to lack of training, and secondly, to the too great encroachment on his time which it involves. The latter reason will, as regards certain cases, always hold good, and the former will not be remedied until the physiology teachers find a niche for psychology in their courses, and until the clinical instruction given to students includes better facilities for the teaching of psychological medicine, especially the study of incipient and early cases of mental disorder—preferably in a psychiatric in-patient clinic as a unit of the teaching hospital. Even if provision of these urgently required clinics out of public funds must be abandoned temporarily, and could there be obtained the legislation necessary to liberate medical action, much could yet be done to bring about these educational reforms without the expenditure of a penny. There is not the slightest doubt but that their accomplishment would enable the general practitioner to be a powerful agent in promoting mental hygiene; for, while he would continue to hand over, for institutional or single-care treatment, most cases of active mental disorder to the specialist—who, as regards single-care cases, and if one may say without offence, too often assumes the position of consultant instead of medical attendant—his widened knowledge would enable him to nip in the bud many a threatened derangement.

As to research in mental disorders and deficiency, and whether it is fair to expect a general practitioner in the course of domiciliary service to conduct such work on serious lines, admits of considerable doubt. Doctors are in no danger of being stigmatised as grasping, nor in relation with their patients has cash payment ever "become the sole nexus of man to man." Nevertheless in their all too leisureless lives, and where the loss of an hour can be estimated in cash, it seems only reasonable that, if they are asked to make records outside the actual requirements of their clinical work, some remuneration should be forthcoming. For example, were the responsibility of directing a mental hospital again mine, among other lessons I have since learnt is the great value to be reaped from a full report from the family doctor of every case admitted; and for such a report one would like to be in the position to offer a fee: some such system would immensely stimulate general practitioners to be on the alert to observe and record facts from the byways of medicine. Again, if the prevention of the occurrence of disease is seriously expected to be based on the domiciliary medical service, would not the most effective means be to take a leaf out of our

dental colleagues' book,[1] and to make a determined effort to educate the public regularly to consult the family doctor in health as well as in sickness? It is undeniably true, and probably happily so, that our countrymen, as lately emphasised by Dr. Addison in the course of the Cavendish Lecture,[2] will never consent to have their lives directed by doctors; yet submission to the removal of the whole of their teeth on the *ipse dixit* of their dental surgeon (whose advice is doubtless given on good grounds), seems not difficult to obtain, whereas the advice, hygienic or personal, tendered by the family doctor at his routine occasional visits would indeed be rarely anything like so drastic. Nor is there need, through over-zeal or lack of tact, to fear the retort—"Thou art always figuring diseases in me, but thou art full of error: I am sound."

(iii) *Certification, when necessary, preferably by the family doctor: unnecessary use of existing emergency procedure.*—Assuredly the general practitioner should have the power to summon a consulting alienist irrespectively of the patient's means. The consultant ought not to be otherwise accessible, and apart from large towns, and not even entirely excepting them, who is there so suitable—indeed, in many districts the only one available—as a medical officer of the public mental hospital or institution for mental defectives? As to this suggestion, the cost of which would be mainly travelling expenses, and these probably met by the saving of later and more expensive treatment, more will be said under "Institutional Treatment." Furthermore, while privately arranged procedure cannot override the statutory position under the Lunacy Acts of the relieving officer, overseer, constable, and Poor-Law medical officer,[3] yet in practice more could and should be done, so that institutional treatment is not invoked except on the recommendation of the family doctor. Pursuing this train of thought still further, it seems to me a misfortune that when certification for the purpose of obtaining admission to a public mental hospital is needed, the services of the family doctor are not more frequently and as a matter of routine called in. Such a custom would be in harmony with the spirit of these Acts; for, while the Justice is empowered to call in whomsoever he chooses,[4] yet when procedure (under Section 13) entailing two medical certificates is used, he is enjoined to proceed so far as possible as if making an order on petition, in which one of the two certificates must, if practicable, be under the hand of the regular medical attendant. The divorce of

[1] *See remarks by Prof. G. Hopkins on the "Future of Medical Practice from the Point of View of Medical Research," British Medical Journal, July 10th, 1920, p. 41; and by Sir James Mackenzie, British Medical Journal, June 5th, 1920, p. 783.*

[2] *"On the Part of the State in the Prevention of Disease," see British Medical Journal, June 25th, 1921, pp. 940–2.*

[3] *See Sections 13 to 16 and 20 Lunacy Act, 1890, and Section 2 of the Amending Act of 1891.*

[4] *See Section 16, Lunacy Act, 1890.*

the family doctor in this matter has doubtless come about partly from the much too general and often quite unnecessary use of Section 20[1] of the Act of 1890, under which persons are taken upon the relieving officer's "three-day order" to the Poor-Law institution, whence, within the ensuing six days—a period which, under a somewhat devious procedure,[2] can be extended to some forty days—the patient is removed to the county or borough mental hospital. Section 20, highly useful as it is, was framed to meet emergencies, and the other sections[2] to meet special circumstances and provide for a period of observation; but when the desirability of mental hospital treatment is obvious and there is no emergency necessitating the immediate provision of accommodation for a night or so, it is wrong, on both sentimental and medical grounds, to submit the patient to this procedure for mere purposes of administrative convenience. By those patients not too ill to realise it, it is greatly resented—as many a one has told me; and, as doctors, we know that the quicker the patient reaches the place of treatment the better, and that, once there, any transfer or dislocation of treatment is greatly to be deprecated. It is for this reason that the institution of anything in the nature of a "clearing house," when providing for mental cases, to my mind is bad administration if it can by any means be avoided.

Some magistrates, too, are not blameless in this matter, in that they affect, not only to satisfy themselves that all is in order, and that in the light of the medical testimony the patient is of unsound mind, but also to constitute themselves judges as to whether the patient *need* be sent to the mental hospital. This is an echo of the time when the main idea in sending a person to an asylum was not so much the treatment he would obtain there as his and the public's protection, and of the altogether-to-be-condemned notion—still too prevalent—that the asylum is the last place to send a person for whom one feels regard. Perhaps the designation of these institutions as mental hospitals will do something to banish this attitude, but probably of still more effect would be the invariable association of the family doctor with the procedure.

(iv) *Need of improvement in emergency procedure for admission to county and borough mental hospitals.*—The hardship inflicted by an

[1] *The section reads: "If a constable, relieving officer, or overseer is satisfied that it is necessary for the public's safety or the welfare of the alleged lunatic with regard to whom it is his duty to take any proceedings under this Act, that the alleged lunatic should, before any such proceedings can be taken, be placed under care and control, the constable, relieving officer, or overseer may remove the alleged lunatic to the workhouse of the union in which the alleged lunatic is, and the master of the workhouse shall, unless there is no proper accommodation in the workhouse for the alleged lunatic, receive and relieve, and detain the alleged lunatic therein, but no person shall be so detained for more than three days, and before the expiration of that time, the constable, relieving officer, or overseer shall take such proceedings with regard to the alleged lunatic as are registered by this Act."*

[2] *See Sections 21 and 24 of the 1890 Lunacy Act.*

invariable and unnecessary use of Section 20, which prevails in some localities, would be mitigated were the place of safety—provision of which is the object of the section—not restricted to Poor Law institutions; but whatever be the place of safety, any needless halt in reaching the place where the actual treatment of the case is to be carried out is strongly to be deprecated. Satisfaction to relatives and to the majority of patients would be promoted, and difficulties felt by magistrates in this matter would be minimised, were it possible for patients requiring to be sent to county and borough mental hospitals to be admitted thereto on an "urgency order" comparable to the mode of admission as a private patient, which can be, and so often is, employed as a preliminary to the completion of an order on petition. Many advantages might accrue from this suggestion, which was among others put forward in 1918 by the English Lunacy Legislation Sub-Committee of this Association.[1]

In what has just been said concerning domiciliary service no little reference to institutional services has been unavoidable, and, in now proceeding to consider those services my remarks can be correspondingly curtailed.

(5) Institutional Services.

Institutional services are explained as comprising primary and secondary health centres, teaching hospitals, and supplementary services; as already stated, it is only among the last-named group that the Report makes mention of institutions for mental cases. But that it was intended or wished to confine psychological medicine to that circumscribed domain we need have no fear, nor indeed should we be right in being content with such a sphere when we bear in mind the important functions assigned to primary centres.

(i) *The primary centre: Should be available for out-patient treatment of mental cases; importance of, and no obstacles to, this form of treatment.*—The primary centre, it is said, "would be the home of the health organisation and of the intellectual life of the doctors of that unit," to which may be added the view of the Post-Graduate Medical Committee[2] (appointed by Dr. Addison and presided over by the Earl of Athlone), that insufficient use is being made of cottage hospitals in country districts, which, it is suggested, ought to be outposts of post-graduate study.

It is unthinkable that considerations appertaining to the mental health of the community can be ignored at such important units as these centres are foreshadowed to become. But whether—apart from

[1] *See Journal of Mental Science, January*, 1919, *p.* 43.

[2] *Their report, obtainable from H.M. Stationery Office, was published in May*, 1921, *and see British Medical Journal, June 25th*, 1921, *pp.* 942–6.

their convenience for mutual discussion between practitioners and for lectures on mental hygiene, which, if graded in scope for adolescents and adults, could be made of much utility in promoting communal mental health—these centres can be turned to account in the actual treatment of mental cases, to my mind depends entirely on whether an out-patient department forms part of their arrangements. It goes without saying, and, indeed, is specifically contemplated, that such a department will be found at secondary and university centres; but the point—vital for our purposes—is left uncertain with respect to primary centres, and there is the ominous opinion of the Council of the British Medical Association[1] that the establishment of out-patient departments for purposes of general treatment would be entirely unnecessary and undesirable. It is greatly to be hoped that this opinion arises out of misunderstanding, and out of an ungrounded fear of encroachment upon the sanctity of the practitioner's surgery and consulting room, and that it will not prevail. The point has been characterised as vital because of the doubtful wisdom of the policy were we to ask for provision (ordinary or special) for beds and in-patient treatment of mental cases at these primary centres, and because of my firm conviction that a hitherto quite unrealised volume of psycho-therapeutic out-patient work could be accomplished at these centres; not only among psycho-neurotic and borderland cases, nor even confined to cases of incipient psychosis, but also in patients that have reached a certifiable stage of mental disorder; and again also in the treatment of so-called moral imbecility; nor should mention be omitted of the great convenience such centres might prove for the examination of school children and others for mental deficiency, suspected on account of failure or delinquency, etc.

It is my strong belief that this place and form of treatment would be productive, if in the right hands, of most gratifying results, would save much distress and incapacity arising out of that feeling of self-insufficiency associated with neurotic ailments, would cut short many an incipient mental breakdown, and in a certain number of more fully-developed cases would obviate institutional treatment. Given the requisite physicians, all this might be widely put in operation to-day without any expenditure other than travelling expenses; in point of fact it does exist at a few centres, and, in the paper to-morrow on "The Oxford Clinic," by Dr. T. S. Good, we shall learn details of what can be done in this direction.

For the successful application of out-patient treatment to mental and allied disorders, not only in results of treatment but in the extent to which cases in the locality avail themselves of it, at least two factors

[1] *See Supplement to British Medical Journal, April 30th, 1921, p. 152, para. 16, and answer to Question 9, p. 154.*

are essential: one is that those who undertake the treatment must be thoroughly competent, and the other necessitates out-patient provision for miscellaneous illnesses—the greater the variety the better. The reason for the latter factor is that many persons—and they may be the ones whom it is most desirable to reach—shrink from presenting themselves at a treatment centre that gets known as dealing only with mental and nervous cases; there are also other reasons, which need not be entered into here, why most of us would rather conduct this work in a well-arranged out-patient department than at the patient's home or in a surgery. As to by whom the treatment should be undertaken, it will save repetition if the matter is left to be considered under secondary and teaching centres; but the necessity of skill and competency cannot be too much insisted on, and therefore the work must not be relegated to those who are comparatively junior, as is unfortunately the custom in most general out-patient departments. Moreover, those who carry out the work must be prepared not only to give the time for it, but, in the case of patients still able to continue in employment and who are not masters of their own time, the doctors may have to arrange the hours of their attendance accordingly.

(ii) *The secondary centre: Should be available for mental cases, both as out-patients and in-patients; for the latter, legislation probably necessary.* —The secondary centre is described as located in towns in one building or more (preferably, but not necessarily, occupying the same site); efficiently staffed with consultants and specialists; adequately equipped with laboratories and such other ancillary services as pharmacy, radiology, electrotherapy, hydrotherapy, radiant heat, physical culture, massage and nursing; and closely linked up with other centres by an ambulance service, all these desiderata having as their object the supply and maintenance, at a high standard, of general medical and surgical services and certain special services, nine of which are enumerated, but among which psychological medicine has so far not been included. We shall be forgiven if we cast more than longing eyes upon such an important unit.

In the first place all that has been said as to out-patient treatment at primary centres applies with even greater force in respect of secondary centres, except for the fact that necessarily they will not usually be so accessible for patients. That point must not be overlooked; but, apart from it, the institution of out-patient treatment at all such existing general hospitals as can be said to correspond with what is meant by a secondary centre would, owing to the dearth of available physicians, be administratively easier to accomplish than at more scattered centres, and surely ought to be proceeded with at once. It is really remarkable, in the face of the admitted importance of nervous and mental illnesses, how many large general hospitals, possessing an otherwise strong

visiting staff, including specialists, are without a neurologist or psychiatrist, or—and better still—a neuro-psychiatrist who, as a foundation for his work, has a knowledge of neurology, psychology and psychiatry: this, too, when sometimes there is at least one such specialist practising in the vicinity of the hospital, and available.

But in regard to secondary centres, it is submitted that we cannot be content with facilities only for out-patient treatment, and that, although general hospitals have hitherto fought shy of making in-patient provision for mental cases, such provision is urgently required, not on the ground that there are not vacant beds in public institutions for mental cases (for there are), but on account of the evil results to patient, physician and student that have accrued from the divorce of psychological from general medicine. The need of more expeditious hospital treatment is widely prevalent, most general hospitals being already short of accommodation, and that is doubtless one reason why those of them that have expressed a readiness to allocate beds for mental cases are so tardy in doing so; so far as known to me, none in this country has done so yet. But deeper than that reason, there is a reluctance and some timidity in taking a step that may be fraught with responsibility of a novel kind, and that demands a knowledge of matters in which the managers and staff may have hitherto had no experience. The establishment of psychiatric clinics (for in-patients as well as out-patients) is part of the declared policy of this Association, and it is therefore our duty, individually[1] and corporately, to do all in our power to break down this reluctance and apprehension; for instance, were general hospitals to be circularised by the Association upon the matter, good might emerge in at least some quarters; again, Visiting Committees of public mental hospitals—and a move from them would be less invidious than from the medical superintendent—either as a body or through individual members, might usefully approach the Committee of Management of general hospitals in their area.

But there are these reservations to make: to escape irritating difficulties, legislation (which need be only permissive and non-committal as to expenditure of money) is practically unavoidable to enable in-patient mental cases to be received; that, while a few beds or a small ward for mental cases on each side of the hospital would be a welcome step and would probably be productive of much indirect good, it would only very partially cope with the requirements we have in mind; and that adequately to meet them, a specially-designed structure is necessary which would be difficult to arrange for within the accommodation for general cases, and which, because also of the desirability

[1] *See "The Position of Psychiatry and the Rôle of General Hospitals in its Improvement," by C. H. Bond, Journal of Mental Science, January, 1915, and Lancet, December, 1919; "The Co-ordination of Clinical Research and the Position of Psychiatry," by E. Goodall, Lancet, August 2nd, 1919, p. 116, and ibid., p. 205.*

of a certain amount of garden, almost necessitates a detached structure as an annexe to the central building. The ideally-disposed psychiatric clinic would seem to be its inclusion among several disparate units on the same site and which together form the general hospital, the whole being known under one name. For it to be effective, the requirements of such a structure involve considerable elaboration, and its construction would be far too costly to expect either general hospitals or local authorities to face such expenditure during the nation's straitened circumstances. While these prevail, the best that can reasonably be hoped at a non-teaching hospital is the adaptation of a part of it (preferably a detached unit) and its utilisation for mental cases, and certain of the municipal hospitals are the only ones that seem at present in a position to spare such accommodation. Different considerations are, however, perhaps permissible in the case of the third form of institutional accommodation, namely :

(iii) *The University centre : Should provide a psychiatric clinic, and thoroughly organised teaching in psychological medicine, as well as treatment facilities.*—The University centre with teaching hospital and medical school, by its very name, connotes the inclusion of all teaching that appertains to medical science, and the exclusion of any one of its recognised branches must always be a source of weakness.

The War's Lessons as to Dearth of Experts and as to Insufficiency of Teaching in Psychological Medicine.

How serious is this weakness may be gauged from the huge number of psychoneurotic and psychotic invalidings during the war. These were in no way novelties which could be counted on to disappear into medical history with the clearing up of the war's aftermath ; the war merely forced our profession and the laity to realise, by having the cases presented to them in mass-formation, the large number of neuropathic persons there are who " carry on " in civilian occupations, battling with their feelings of self-insufficiency as best they may, and the still more numerous others in whom these conditions are latent. But the war did more, in that, owing to the presentation of these cases in their thousands, it forcibly drew attention to their curability, provided that really skilful treatment at the hands of specially trained doctors was obtainable. To-day, as the result of schemes of intensive training, put in force by the Director-General of the Army Medical Service and carried out largely by mental hospital physicians, there are many times more doctors capable of carrying out this treatment than there were before the war, but still by no means sufficient to cope with what is required. This shortage is the more serious because, if the Universities are unable to provide the requisite teaching—and most of them seem willing enough to do so if means were forthcoming—the number of specially trained doctors will gradually diminish after the extra-mural emergency teaching centres have closed down, and because the available teaching for existing mental hospital physicians, who are without this special training but eager to get it, is as yet far from accessible to many of them.

Need of Schools of Psychological Medicine.

A very strong case, therefore, presents itself for vigorous action at University centres, and the wiser course would seem to be—while doing all possible to get mental out-patient work instituted at every secondary centre and at such primary ones as practicable, and while encouraging, where circumstances are favourable, the establishment of in-patient clinics at secondary centres—to concentrate our efforts at University centres. No University granting medical degrees should be

content without its School of Psychological Medicine, by which is meant a team of teachers giving instruction in the comprised subjects,[1] adequate clinical and laboratory facilities, and lastly, but not least, a regular supply of undergraduate and graduate students with their sprinkling of research workers. None will doubt the wisdom of the Post-Graduate Medical Committee in urging separation of graduates from undergraduate teaching, but psychological medicine is a branch in which this principle is probably sufficiently and best adhered to at most places, save perhaps in London, by arranging their respective tuition at different hours.

As to adequate clinical and laboratory facilities, the matter would be met in the main by the existing ones in or attached to the medical school; but clinical requirements cannot be said to be satisfactory at any centre as yet, the deficiency being especially in the field available for the study and treatment of cases in their earliest stages, and the prevailing necessity to rely entirely on the mental hospital, usually situated at a considerable distance from the teaching hospital. These clinical requirements comprise (*a*) a supply of neurological cases preferably collected in special wards or in a detached unit of the hospital; (*b*) the psychiatric clinic located in the manner already indicated, but with provision for its out-patients forming part of the hospital's general out-patient department, and (*c*) the county or borough mental hospital and the corresponding institution for mental defectives, which, if regarded as part of the supplementary services,[2] ought to be brought into intimate relation with the University centre, as well for their own sake as for the supply, for teaching purposes, of certain stages of mental illness which will always be best studied at a large mental institution.

Absence in this Country of Psychiatric Clinics.

Apart from the Maudsley Hospital, which still awaits equipment and organisation, and the arrangements now being made at Bethlem Hospital, our country is totally without a psychiatric clinic providing in-patient treatment—a most lamentable statement to have to make—nor do either of those two hospitals form an integral unit of a general hospital. It is, however, only fair to remember that at mental hospitals—which for so many decades have borne the heat and burden of the day's work in the difficult task of treating mental illnesses, and where, I am convinced, it will continue to be borne—the practice has been growing up of providing detached buildings, generally spoken of as "admission" or "acute" hospitals (the latter term, it is hoped, will fall into disuse), for the reception and treatment of recent cases, with small, ancillary villas for convalescing patients.[3] These admission hospitals are prototypes of the psychiatric clinic, and the best of them contain many of the essentials of what is meant by that term; still, as any University centre desiring to provide itself with one would naturally seek to know what we have in mind, and although they will doubtless not be stereotyped in design, but will reflect the application of many minds, the following particulars may not be out of place.

The Psychiatric Clinic: Its Requirements.

The psychiatric clinic (1) should not have more than two storeys for use by patients; (2) should contain day-rooms for sitting and dining purposes, with two or three still smaller sitting-rooms for the use of one patient and nurse, dormitories, and a sufficiency of single rooms; (3) all these rooms so arranged as effectively to protect quiet and sensitive patients from the distressing symptoms of disturbed and actively acute cases, each of these two groups of cases probably needing facilities for further subdivision; (4) a small solarium and liberal verandah space to provide open-air treatment, so distributed as to enable the classification just indicated to be maintained and single-room cases to have open-air treatment in isolation; (5) waiting-room; (6) admission and medical officers' clinical rooms—at least two; (7) nurses' duty-room; (8) store-rooms for clothing and bedding and

[1] *See "The Need of Schools of Psychiatry," by C. H. Bond, Journal of Mental Science, January*, 1920.

[2] *See Paragraph 74 of the Council's Interim Report.*

[3] *See "Hospital Treatment of the Insane, etc.," by C. H. Bond, British Medical Journal*, 1902.

boot-room; (9) staircases placed to provide alternative exit in case of emergency; (10) ablution baths, lavatories and other sanitary accessories accessible without intermingling of classes of patients; (11) liberal hydrotherapy equipment and some facilities for electro-therapy and radiant heat; with the exception of these three services, and the necessity of a certain proportion of the nursing service being fully trained in mental nursing, the remainder of the ancillary services enumerated under secondary centres would be provided from the general facilities of the hospital; (12) a small detached cottage for convalescing patients—whether a few bedrooms for nurses would require to be provided in the clinic would depend on its proximity to the hospital's nurses' home; duplication of each of these twelve items would be necessary to provide for both sexes, but the remaining six might well be arranged for the use of both sides of the clinic; (13) kitchen with larder and servery; (14) nurses' mess-room; (15) servants' mess-room; (16) a small clinical laboratory—the medical school laboratories being mainly relied upon; (17) psychological laboratory, and (18) two lecture-rooms.

This is a formidable list, but none but essentials have been included, and to erect such a structure to-day would cost, according to competent advice, not less than £800 a bed. Urgently as these clinics are wanted, what likelihood is there of such sums being forthcoming out of public funds? Except there can be aroused in some locality a strong sentiment in favour of doing something for the cause of psychological medicine, or short of another instance of princely benevolence in its behalf, obviously patience must be exercised until financial tension is relieved. The matter should, however, be constantly ventilated, and the dearth of these clinics kept well before the attention of University and local authorities; better still, if they can be persuaded to resolve to have such a clinic at the earliest practicable opportunity, and in the meantime seriously to consider plans and other arrangements, a project actually in embryo is much more likely to mature than one *in nubibus*. Acceptance of the inevitable does not, however, involve a policy of marking time. Such teaching arrangements as are feasible can be proceeded with at each University centre, and for clinical facilities reliance will have to be placed on out-patient work at the general hospital, in the organisation of which, if there is the will to do so, no delay need occur; on neurological cases, in the hospital; and for mental disorders, on the cases at the neighbouring mental hospital. This leads to the consideration of supplementary services, which will conclude what has to be said concerning institutional treatment.

(iv) *Supplementary services.*—Supplementary services, as already stated, are shown in the report as including, among others, institutions for mental defectives and hospitals for curable or incurable mental disorder. As is well known, and owing to the comparative recency of the Mental Deficiency Act and the intervention of the war, the country is not nearly so completely supplied with mental deficiency institutions as with hospitals for mental disorders; still, of the Universities in England and Wales, scarcely three can be said to be seriously deficient in a clinical field for instruction in mental deficiency.

Mental Hospitals in England and Wales.

As to institutions for mental disorders, of the fifty-two counties in England and Wales, eight in Wales and only three in England are without at least one county or borough mental hospital in their area, and each of these eleven counties has acquired a share in the accommodation of a mental hospital in one of the contiguous counties. Enough has been said to indicate that, though we may be prepared to accept their inclusion in the supplementary services on the score that they receive none but mental cases, and perhaps also because they are the only hospitals where detention is combined with treatment, and while we believe that the treatment of many curable cases is destined to be always carried out at these mental hospitals, we cannot admit that the study and treatment of incipient, recent, and curable mental disorder can be permanently relegated to a supplementary position; it is imperative, and must be repeated *ad nauseam* until translated into fact as well as conceded in theory, that a recognised place be found for them in the heart of general medicine. Nevertheless, as the ninety-seven county and borough mental hospitals and, so far as practicable, the thirteen voluntarily supported hospitals, constitute the principal asset which our specialty has to offer in a comprehensive scheme of medical and allied services, some reference to them beyond their mere mention seems necessary.

How valuable are they as an asset in the partnership of medicine is all too little known by the public and ratepayers whose money has provided them, some of whom—often on the strength of statements of patients discharged but not fully recovered, or, if recovered, still retaining distorted recollections of their illness—do not scruple to make gross aspersions against all that concerns mental hospitals without ever having been within the curtilage of one. Apart from unworthy motives of advertisement, this attitude, which seems to attach itself with peculiar readiness to mental institutions, is very difficult to understand. Its cure is their closer partnership with general medicine, the avoidance as much as possible of isolation, the encouragement of unofficial lay visitors and the institution of committees of ladies, who, unconnected with the management, regularly visit the patients in their wards—such as was so successfully done at war hospitals, as well in their mental as in their general wards. In this manner would grow up a solid mass of well-informed opinion, against which malevolent allegations would be found too powerless to make their publication worth while. Differing as they do in age from over a century to one in course of equipment, they vary widely in facilities. But, were it needed, irrefragable proof of their general excellence is always forthcoming in the fact that twenty-three of them, including the oldest in construction, were utilised as

war hospitals during the Great War, mostly for general medical and surgical services, and proved so satisfactory, that not only did one-sixth of our sick and wounded from all fronts pass through them, but it was common knowledge that the military authorities—and we are glad to have with us to-day the Directors-General of the Medical Departments of the Army and Navy—ever seeking further accommodation, expressed a preference for our mental hospitals as well on account of their design as of the completeness of the organisation handed over with them.[1]

The ability to make such a generally satisfactory statement should not, however, blind us to any defects or deficiencies either in their internal arrangements or in the treatment they provide, nor should the fact that the making good of some of these imperfections has to be postponed lead us to refrain from keeping them well under the notice of the public, empty though its purse may be.

Institutions for Mental Disorders must be Hospitals in Fact as well as in Name.

It is but comparatively recently that the term "mental hospital" has largely replaced that of "asylum," and the rapidity of its unofficial adoption, despite the proverbial relationship between a rose, its name and its smell, is not without significance, for nowadays we all know something of "conditioned reflexes," and are more inclined to admit the magic and even superstition of a name; hence the ready acceptance of this change, which was both timely and in the right direction, though as to the necessity or wisdom of the inclusion of the word "mental," there may be room for doubt. This change of designation, however desirable it may have been, should at least carry with it the determination that those institutions shall be hospitals in fact as well as in name, and therefore it is hoped apology is not needed for laying some stress on the following matters.

(i) *Importance of classification of patients.*—Classification of the patients is of fundamental importance; and if there is one lesson from the experience gained in mental wards of war hospitals which stands out more than another, it is the potency of the atmosphere of hope which is created by the witness of recovery in others, and by an attitude of "why" rather than "what" on the part of the physician—by an endeavour, that is, on his part to understand the mechanism of the patient's conduct rather than resting satisfied with labelling it. This atmosphere can only be attained by adequate separation of recent from chronic cases, and the prevention, for instance, of an observant patient taking alarm, and voicing it, as has been done to me, at learning that his *vis-à-vis* has been twenty years in the institution; moreover, such

[1] *See "History of the Asylum War Hospitals in England and Wales: Report to the Secretary of State for the Home Department," by Sir Marriott Cooke and C. H. Bond, May,* 1920.

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separation affords the best means of focalising skilled treatment on these cases. But their classification has to be carried still further—(*a*) so as to provide a small unit as a half-way home for convalescing patients, who should be moved there—even contrary to their desire—at the earliest safe date, in order to get them away from sight and hearing of the morbid mental symptoms inseparable from the admission unit; and (*b*) so as to ensure adequate sub-classification and real mental nursing while in the admission hospital. Obviously a large ward of simple design and capable of being supervised by a minimum of staff cannot possibly ensure these ends, nor can parsimony in staff and a mere sufficiency to secure safety be justified by any considerations of economy when dealing with presumably recoverable cases.

(ii) *Unnecessary institutional customs should be avoided.*—Avoidance of any unnecessary enforcement of institutional customs upon patients likely to be discharged after a few months' treatment may also play a part in begetting an atmosphere of recovery. Particularly in my thoughts is the dislike not a few patients feel, especially if it is their first admission to hospital, at having to doff every article of their own clothing—which, moreover, is usually at once sent away—and at having to don the institution's garments. In many cases, but far from in all, this substitution is unavoidable; but even so, their own clothing might, whenever possible, be retained at least for a limited period and for use during convalescence. This more benign course is in practice at a few mental hospitals, and might well be extended. In this connection we recognise the truth in the proverb that "meat and cloth make the man," and it leads me to say a few words upon the important matter of our patients' food.

(iii) *Dietary.*—Suitability of dietary has, as we all know, both a psychological and a nutritional import, and the two aspects have a mutual reaction. The former was vividly pointed out in the paper[1] read to us in February, 1919, by the Professor of Physiological Chemistry in the University of Glasgow, and there is undoubtedly a *spes cenatica*, which has its influence in building up the desired atmosphere of hope. Monotony, absence of relish, and a standard distinctly inferior to that which patients have been accustomed to in their own homes are, when they obtain, serious blemishes. Manifestly, a careful classification of the patients enables the cost of their remedy to be thoroughly justified, whereas, if corresponding advantages are distributed indiscriminately over the many chronic cases unable to appreciate them, the administration is open to a charge of extravagance. Upon the nutritional aspect of the dietary, in the face of the bitter lessons of the war, it is unnecessary to dwell other than perhaps to emphasise the great importance to medical

[1] "*Psychic Secretion: The Influence of the Environment*," *by Lt.-Col. E. P. Cathcart, Journal of Mental Science, July*, 1919, *p.* 180.

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administrators, who have to advise lay Committees upon this matter, of a competent knowledge of the facts set out in the Report[1] of the Medical Research Committee on the present state of knowledge concerning accessory food factors. Deference to these vitamines must not let us lose sight of the importance of other food values, but a careful perusal of this report shows how fatally easy it is—in these days of margarine, tinned foods, shortage of fats, sometimes an absence of uncooked fruit and green-stuff, and in some places the practice of using skimmed milk in the preparation of food—to arrange a dietary sufficient in bulk and otherwise apparently satisfactory, but which by being deficient in these accessory factors may expose the patients to the risks of lowered resisting power.

(iv) *Freedom of discharge.*—Freedom of discharge may sound a strange point to raise when we know that, besides the many patients discharged as recovered, who number rather more than 33 *per cent.* of the yearly admissions, there are at least a further 6 *per cent.* who are discharged as relieved—mostly to care of friends. But the fact remains that a private patient, apart from authority vested in Commissioners and Visiting Committees, can in general be discharged by order of the person making the payments or by the next-of-kin, whereas no such power remains with the relatives of an ordinary (so-called pauper) patient. This is probably the cause of a not uncommon expression of opinion that it is easier to get into than out of an asylum; this notion without doubt is a deterrent to institutional treatment being sought early, and if possible should be dispelled. The only real grounds for it are the refusals made solely in the patient's interests to application for discharge, generally on the score either of inadequacy of supervision at home or of its jeopardising chance of recovery. If the latter is likely to be seriously endangered and there is a fair chance of its occurring by a few months' more treatment, the refusal is certainly justified; but there are cases—at least so it has seemed to me—in which while after prolonged treatment recovery seems unlikely, the patient's discharge has been refused on the ground (probably perfectly true) that he cannot be successfully managed at home, and in which, if danger to self or public is not feared, the discharge of the patient, though against his best interests, would have been the wiser course, as being likely to promote public satisfaction and the general good of psychological medicine. The wasted trouble and expense, including that of recertification which is deemed likely to be speedily necessary, have been cited as difficulties, but this is quickly counterbalanced by the patient's being no longer maintained at public cost, and, if there are graver doubts as to his fitness, there is always at hand the method of first allowing him out on trial.[2] In this connection, though not quite on all fours with

[1] *Special Report Series, No.* 38, *published* 1919, *obtainable from H.M. Stationery Office, price* 4*s.*

[2] *Under Section* 55 (1) *of the Lunacy Act of* 1890.

it, the experience gained at the Norfolk County Mental Hospital in the course of its temporary conversion into a war hospital is well worth keeping in mind. There, instead of, as in normal times, awaiting and closely scrutinising application by the friends on behalf of unrecovered harmless patients, the friends of such cases were approached in writing and requested to receive them; in all some fifty cases were successfully so discharged,[1] and that, too, without the inducement of pecuniary assistance—not more than three of them being known, after a considerable interval, to have relapsed. A few others were somewhat similarly provided for by giving them the pecuniary help available under the Lunacy Acts; this, as you know, can be granted either when the patient is out on trial,[2] or while boarded[3] out under the charge of a relative or friend who must have made definite application to be allowed to have the patient; the term "friend" has to be here construed literally, and may not be merely someone selected for the purpose. It is to be observed that this English system of boarding-out differs from that used in Scotland, in that the Reception Order remains in force and requires to be renewed at the statutory intervals. The difficulty of this requirement doubtless partly explains why so little advantage has been taken of the system in this country; but, if it would decrease the burden of institutional care as a cost upon the public, it might be worth while considering whether these difficulties would not be found to have now largely disappeared by the extended use of the motor car. We certainly owe a duty to do all that is legitimate to decrease these burdens.

(v) *Clinical records and facilities for clinical work.*—Clinical records and facilities for good clinical work possess an importance as respects both treatment and scientific progress which needs only mention to receive acceptance. The matter is only raised here to reiterate a conviction that, although an adequate and complete physical examination can perhaps be made of a patient while in bed in a dormitory and with sufficient privacy by the use of screens, no satisfactory mental examination can be made, nor can therapeutic conversation be effectively employed, in the absence of a suitably placed clinical room, which, if properly equipped—and this involves but trifling expense—also greatly adds to the convenience both of the physical examination and of note-taking. My own experience of their value is such that, in my opinion, no mental ward should be without one, two being probably required in each admission hospital if the institution is a large one; with respect to position, direct access to them should be possible for patients in bed without their having to traverse a day-room. As to note-taking, so often the bugbear of the medical officer, to be of any real value it must

[1] *Under Sections 77 and 79 of the Lunacy Act of* 1890.
[2] *Under Section* 55 (2) *of the Lunacy Act of* 1890.
[3] *Under Section* 57 *of the Lunacy Act of* 1890.

be done *vis-à-vis* the patient, and, if suitable facilities exist for so doing under a well-considered scheme of clinical records, no irksomeness is felt by one interested in his work. By those of us who have had the experience of doing their clinical work both with and without these great advantages, no little surprise is felt that they are not instituted in all instead of in the minority of our mental hospitals.

Hitherto, in those hospitals where such a scheme obtains, it has involved clerical assistance to get the notes copied[1] into the case-books; but now that these are so often on a loose-leaf system, the whole question of clerical records seems ripe for reconsideration, and if the difficulties with which we are all familiar can be overcome, a big step will have been taken towards the amassing of clinical material of real service to an investigator endowed with a synthetical mind.

Medical Staffs of Mental Hospitals.

The medical staff of mental hospitals has rightly been the subject of much recent attention both in circulars issued by the Board of Control[2] and on the part of this Association, as well as in medical and other papers. The points on which stress has been laid have been the pressing necessity of better social conditions for assistant medical officers, the provision of houses for those who are married, improvement in facilities (including study-leave) for training in their specialty, and a recognition that treatment of mental disorders requires the expenditure of much time at the hands of well-trained and highly-skilled physicians, and therefore that some increase in the number of medical officers is called for. The general acceptance and sympathy with which these proposals have met is gratifying so far as it goes; but, taking the country as a whole, disappointingly little has been done in the matter, and it is indeed time that words should be translated into action. Passing from those points, there are three other subjects relating to the medical staff, consideration of which, it seems to me, might lead to much advantage, namely, the institution of a visiting staff, the better organisation of the resident staff, and their position in the public service.

(1) *Institution of visiting medical staffs.*—The institution of a visiting medical staff at mental hospitals is no new idea; in fact, it was much more common many years ago than now, but probably owing to the light in which it was regarded and utilised it seems to have out-

[1] *This system of note-taking* vis-à-vis *the patient and in which the medical officer's clerical work is completed in the wards, save for his subsequently initialling the entries in the case-books, owes its inception to Dr. T. E. Knowles Stansfield at the Banstead Mental Hospital, whence it was later elaborated under him at Bexley. Conjoined with arrangements whereby only a small number of notes fall due daily, the system is productive of clinical records of high standard.*

[2] *See Board of Control's circular of March,* 1920.

grown its popularity. It is more than ever my view[1] that the resident staff at a mental hospital, especially its senior members, should be regarded as—and should, in fact, be—mental experts, and that as such, whilst their skill as specialists should doubtless have been founded on a sound general professional knowledge, they should not be expected to profess either the experience of a consultant in general medicine or, and still less, expert competency in operative surgery and in other special branches. In cases of emergency, especially where a major operation may prove necessary, they have always been authorised to call in expert assistance; but it is in relation to the routine work of the hospital that the demands of modern medicine need a visiting staff, on which should be included a general physician, an operating surgeon, radiologist, and a dental surgeon, and, in the larger institutions, representatives of the other special branches usually comprised in the visiting staff of a large general hospital. Their visits should be regular and not merely as consultants on summons, and before one or more of them should be brought, for mutual consultation with the resident staff, all cases presenting some condition upon which the latter feel a further opinion would be helpful, and at least the majority of all newly-admitted patients. Some insistence upon mutual consultation seems necessary to combat the much less desirable practice of merely asking for a report. The newspapers have done good service, while voicing medical opinion, in awakening a "dental conscience," and the number of mental hospitals in which this matter is receiving proper attention is rapidly growing, but this should only be regarded as a small beginning towards the institution of a full visiting staff. The cost involved is small; for instance, at the Graylingwell Mental Hospital, where the visiting staff are four in number, the total cost—among other interesting particulars kindly supplied me by Dr. Kidd—is about equal to that of one junior medical officer. It needs but little imagination to visualise the many advantages which would accrue to individual patients, to the members of both resident and visiting staffs, to our specialty in general and to medicine as a whole, were such a scheme of medical services in vogue at all our mental hospitals and at all the larger institutions for mental defectives.

(2) *Organisation of the resident medical staff.*—The organisation of the resident staff, as implied here, includes topics not easy to ventilate on an occasion such as this—some which can best be dealt with in committee. It must suffice to say that the creation of a mental hospital medical service, which is sometimes adumbrated as a remedy for a certain amount of dissatisfaction that is occasionally voiced, is probably not only impracticable but unnecessary in order to obtain

[1] *See "The Need for Schools of Psychiatry," Journal of Mental Science, January, 1920, p. 12.*

the advantages claimed for it. Independent local action on the lines suggested by the Board of Control in their circular of March last year can, and probably will, effect a good deal; but much more might be possible by concerted action by Visiting Committees. Their use of the word "hospital" in connection with their institutions marks the presence in their minds of aims and principles which, were they extended to the terms by which their medical posts are designated, would certainly give satisfaction to many of the holders of those posts; thus, though the term "medical officer" is statutorily restricted to the medical superintendent and necessitates the use of the word "assistant" to all the others, no matter how great their experience, there is nothing to prevent, if so desired, the employment of the hospital term "physician" in its various grades from "house-physician" to "physician-in-chief," adding to the latter and to the post immediately below it the respective administrative terms "superintendent" and "deputy-superintendent." It ought not then to be difficult to arrive at common agreement what salary each of the medical ranks should carry, leaving the sum payable as "charge pay" to the superintendent and his deputy variable locally according to circumstances, such as size of the institution; upon the latter circumstance and the nature of the work undertaken would depend which of the medical ranks would be included in the staff and the number of their holders. In arranging their work it seems very desirable that the individual treatment of recent cases and of others in need of really skilled mental treatment should be entrusted to only those on the staff who have this skill, and, as this work occupies much time, the junior members should relieve them of duties which interrupt such treatment. Subject to the necessarily paramount position (medical and administrative) of the chief physician and superintendent, as large a share as practicable of actual responsibility should be accorded the senior members, and a sense of this would be promoted were they expected to submit an annual report of their clinical work to the superintendent. In the making of these appointments, especially the chief ones, professional satisfaction would be promoted were the advice of those who can act as medical assessors more often sought; and, where the institution is in the vicinity of a University, means might with advantage be found for giving the latter a voice in certain of the appointments—in illustration of which mention may be made of the new rules under which the Physician-Superintendent at the Royal Edinburgh Asylum is appointed and holds the Chair of Psychiatry in the University, of the recent appointment to the Chair of Public Health at the Sheffield University in accordance with their declared policy of associating the public health work of the city with instruction given at the University,

and of the Chair in Psychiatry at the University of Sydney, which in future will be filled under arrangements[1] jointly made between the Government Department of Lunacy and the University Senate.

(3) *Position of the resident medical staff in the public service, and the necessity of "fluidity" of service.*—The position of the resident staff in the public service is by far the most important of these three subjects relating to medical staff. It is the key to any chance of progress on the lines of my theme; but as at present regulated, it is, in my opinion, far from satisfactory, and might be placed with much advantage on a broader footing. The medical officers of mental hospitals are whole-time officials—which is as it should be—whose work, under the rules of their service, is rigidly restricted to the duties of their institutional post.[2] Doubtless, should the Visiting Committees of mental hospitals ultimately become members of a county or borough health committee, the mental health of the area will be considered as a whole, and responsibility for it will not be limited to the maintenance of the mental hospital. But there is no need to wait for that consummation, and, as has been one of my objects to show, there is a field of work whose harvesting is much overdue. In the large cities possibly other men can be found for this work, and it is certainly not my suggestion that anyone capable of doing it and able to give the time should be ruled out. There is room for all such; but in most areas, and probably for many years to come, reliance will have to be placed upon the medical staff of the mental hospitals and institutions for defectives. The principle, it is therefore my desire to emphasise and urge strongly, is that these officers should be regarded as public officials, whose services as specialists, notwithstanding they hold resident institutional posts, should be freely available at all centres in their locality at which either mental treatment or the diagnosis of mental conditions is required as part of the public's medical and allied services. This fluidity of service—if one may so term it—would enable much preventive and early treatment, now neglected, to be performed; nor would that be at the expense of institutional duties: on the contrary, the constant touch kept with the periphery, the witness of the operation of predisposing factors, and the acquirement of better knowledge of premonitory symptoms and early stages of mental disorders would broaden the observer's outlook, and without doubt much enhance his effectiveness within his institution.

[1] *See British Medical Journal, May 7th, 1921, p. 684.*

[2] *Subject to the superintendent being allowed to visit, at request of a Secretary of State, any prisoner charged with a capital offence, and executing at request of the Commissioners a Lord Chancellor's Order to visit and report upon a case. At a few institutions he is allowed, when called in as a consultant, to see persons suffering from mental disorder within the area. He is sometimes consultant to the local authority under the Mental Deficiency Act, and in one instance the rules provide for his performing certain duties within the neighbouring University.*

PURPOSES FOR WHICH FLUIDITY OF SERVICE IS REQUIRED.

It is, however, not alone for routine therapeutic work at clinics and at out-patient departments of general and municipal hospitals that this fluidity of service is needed, and, in bringing my remarks to a close, it is my wish to touch on four relationships which psychological medicine can claim, and to urge that there are steps our Association can take to establish them on a firm footing. These four are its relation to medical services for school children, to criminology, to industrial hygiene, and to the naval and military medical services. In the absence of more than a smattering of personal experience of these matters my observations will be brief; but deficiency on my part will, as regards two of them, be amply met by the papers[1] we are promised to-morrow from Dr. Auden and Dr. Myers.

(1) *Psychological medicine and the school medical service.*—The medical services required for children at school are numerous, and we are only indirectly concerned with the question as to the extent to which they can or should be undertaken by the general practitioners of the families to which the children belong; though, if consulted on the mental condition of a child, we should doubtless feel more dependence on the wider and more useful facts obtainable from the doctor, who has intimate knowledge of all the members of the family, than is possible from one who knows the child only in school. But to whatever extent examination and treatment of school children ultimately devolve on general practitioners, the recognition (*a*) that social efficiency is the goal; (*b*) that though failure in its attainment may have a purely physical basis, there are educational and sociological problems which need a special training in psychological medicine, particularly in educational psychology; and (*c*) that psychoses and psychoneuroses developing in adult life are not infrequently traceable to childhood's experiences and buried difficulties which were inadequately dealt with in childhood, are all circumstances which dictate the necessity of a school medical officer possessed of special training and much skill. In populous and important centres this already obtains; but, so far as one is justified in speaking with only outside knowledge, neither his nor any other mental expert's services are available as a matter of routine in many country districts. Here, again, fluidity of service of public officials seems highly desirable. The medical staff of the public mental hospitals might well, under a recognised scheme, be available for the school service; and correspondingly, where the school medical officer undertakes psychological work, part of his time might with equal advantage not merely be available on summons, but be definitely assigned for visiting duty at the mental institutions; the former would thus maintain his touch with early conditions, and the

[1] "*Mental Defect and the School Medical Service*," by *George A. Auden*, and "*Psychological Medicine in Relation to Industry*," by *C. S. Myers*.

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latter would see acute and terminal phases from an angle that might possibly suggest preventive measures, and both of them would have the chance of considering not only types in groups, but also of learning many a lesson by watching changes of phase in cases known to them from early school age. In passing from school service topics, it seems opportune to ask whether the routine examination of school children has not been inaugurated long enough now to enable the medical staff of institutions for both mental disorder and deficiency to be furnished, under some mutually convenient procedure, with a report of the school years of the younger of the patients admitted—in course of time it will, of course, be available for all. I can call to mind many a case in the treatment of which such information would have been of material assistance to myself and colleagues.

(2) *Psychological medicine and criminology.*—Criminology has just received a contribution of fascinating interest and of far-reaching importance, and any words from me can only fall very flat when you read *The English Prison System*, by Sir Evelyn Ruggles-Brise, printed for private circulation at H.M. Convict Prison at Maidstone, and the significance of which was duly recognised by the digest and leading article which appeared in the *Times* a fortnight ago. By the courtesy of its author and of the Governor and Medical Officer of H.M. Convict Prison at Birmingham, a full opportunity was given me a few months ago of seeing the highly important psychological work that is being conducted there and at the Courts of that city; and, but for the fact that the Assizes are being held there this week, we should have been favoured with a personal account of it from Dr. Hamblin Smith. There is available, however, his and Dr. Pott's report,[1] presented last October to the Justices of the City of Birmingham, from which most interesting details can be learnt. It is certain that a great unity of thought in legal and medical minds is taking place as to the relation between punishment and treatment, and that, while recognising that when a criminal act has been committed the last word must remain with the Crown, it is yet possible to abandon a "legal tariff" for crime and give medical science an opportunity of exerting both its reclamatory and preventive influence, and this, too, without the introduction of any mawkish sentimentality. At present it seems that it is only selected cases that are referred for medical opinion and advice, but it is to be hoped that the time will come when it will be possible to arrange for a much more routine and extended application of these methods, especially as regards first offenders. A suggestion has been put forward that this application shall be concentrated at a few

[1] *Obtainable from the Clerk to the Justices, Victoria Courts, Birmingham; see also "The Mentally Defective and Unstable brought before the Courts," by W. A. Potts, British Medical Journal, April 3rd, 1920, p. 472.*

centres. Conscious of one's own ignorance of these matters one hesitates to criticise; but it does seem to me that concentration, though it may possess distinct advantages, cannot satisfactorily meet the case when the movement spreads, as it undoubtedly will. Only quite lately one of the newly-appointed women Justices asked me whence and how it would be possible to obtain expert medical opinion upon the many cases brought before her, which she sees clearly enough are problems incapable of solution by a sentence of punishment. Within walking distance of her court are two mental hospitals with some seven or eight medical men, each of whom would be capable of rendering most valuable assistance. Is there not here, again, a distinct call for fluidity of service; and, where prison and mental hospital are not inconveniently far apart, would not by mutual arrangement the services of the prison medical officer, who is an expert in criminal psychology, be of corresponding assistance in not a few of the cases that find their way into mental hospitals?

So important has become the relationship between psychological medicine and the work of both the school and the prison medical officer that there is a doubt in my mind whether our Association is taking as useful and active a share in these matters as it might. We are fortunate in having among our members several distinguished representatives of these services; we would like to enrol them all, but there is a limit to the number of societies which we can be individually expected to join. Could not this difficulty be met, and with the certainty that advantageous results would emerge, by the setting up of standing joint committees, whose duty it would be to keep this Association and the other respective socities adequately informed upon matters in which we can mutually assist one another?

(3) *Psychological medicine and industrial hygiene.*—Industrial hygiene, in two words, embodies principles which must inevitably affect the health, wealth and happiness, and therefore the status, of any country that either practises or neglects them. It may without doubt be claimed as the offspring of the great factory and other analogous reforms in which this country led the way; but, as now understood, it owes its impetus to activities which until recently have taken place chiefly in the United States, where the value of studies in occupational diseases seems to have been more adequately recognised than anywhere else. But fortunately it has now taken firm root in our own country—the result mainly of the initial work of the Health of Munition Workers Committee, which was continued in the Welfare and Health Section of the Ministry of Munitions, and subsequently developed by the Industrial Fatigue Research Board, constituted in 1918.[1] Industrial clinics are

[1] *Their First Annual Report, obtainable from H.M. Stationery Office, wa published in* 1920.

springing up in various centres at the instance of several of the larger industrial companies, and it is being realised that, apart from the duty owed to the person employed of protecting and curing him of maladies engendered by his work, medical science, besides sometimes providing what is necessary when the wheels of the industrial machine are creaking, can when consistently employed serve the still greater function of preventing friction, thereby promoting harmonious working in the human machinery. In this work—and not alone in connection with industrial fatigue[1] and the nervous and mental disorders to which it gives origin, but also in the recognition of industrial misfits and the adjustment of minor disputes—psychological medicine is already playing an important part. Whether fluidity of service can be of assistance here is obviously very doubtful: probably not. But once assured of the practical value of this or that branch of medical science, industry can be trusted to find her own means to secure its application.

(4) *Psychological medicine in the naval and military medical Services.*—The naval and military medical services can, with some truth, be said to provide our Association with a new sphere of interest. Prior to the war the principal provision in them for mental cases was confined to the Royal Naval Hospital at Great Yarmouth and a block for some 100 beds annexed to the Royal Victoria Hospital, Netley, and, except to a minor extent in the Army, in neither service was psychological medicine included as a branch of medicine in which officers could be officially recognised as specialists. Since the relinquishment by the naval and military authorities of the war hospitals lent to meet the increased demands of both services for additional accommodation for the treatment of nervous and mental cases, those two hospitals, I believe, still retain the two principal units for mental treatment. But the amount of work in this line required during the war—in which so many members of this Association took an active share—the problems it opened up, and other problems of recruiting and training in which it was found help could be obtained from psychological medicine, have established relations between our specialty and the Services which are likely to be permanent. It is of no small interest to us to know that mental diseases is now one of the twelve subjects in which an officer in the Army, not above the rank of lieutenant-colonel, may be granted additional pay (at the rate of 2*s.* 6*d.* daily) while acting as specialist in a post considered to merit the grant. There does not appear to be any system of occasional study-leave, but all medical officers are required to come up to the Department's College in London for twelve months: half of this period is devoted to general medicine and surgery and the other half to the

[1] *See "Industrial Fatigue," by C. S. Myers, British Medical Journal, January 22nd, 1921, p.* 205.

study of such special branch as the officer may select. In the Naval Medical Service five months' study-leave is given on full-pay for promotion to surgeon-commander after eight years' service, periods of three months to senior medical officers as opportunity occurs, and surgeon-lieutenant commanders may be given study-leave in addition to that for promotion. Naval officers may be appointed as specialists up to and including the rank of surgeon-commander; their number is limited to forty-six, and each receives additional pay at the rate of *2s.* 6*d.* daily during the period of his appointment. Officers can choose the subject in which they wish to specialise. The number of subjects is seven, but up to the present psychological medicine has not been included—an absence we shall all hope is only temporary, for there are good grounds for believing it is not for lack of interest in the subject. No officer in either service is at the moment in possession of a Diploma in psychological medicine, but about four naval officers hold the Certificate of this Association. It does not appear that either service has as yet contemplated the possession of one of the diplomas in psychological medicine (which are granted by six of the Universities and the Conjoint Board in London) as a *sine quâ non* to recognition as a specialist in this subject. Should such a rule be ultimately adopted, it is manifest that the Army's existing arrangements would easily lend themselves to the requirements of at least three of these diplomas, but in the case of the Navy, while it seems that an officer could reasonably easily obtain sufficient study-leave (three months) to enable him to proceed to Part I of the examination, he would have either to defer Part II until another period of study-leave was due to him or to obtain a further three months' special leave, possibly on half-pay. It is apparent, too, that the exigencies of the Naval service may make it difficult for officers to find the necessary clinical opportunities required for these diplomas; but in their favour is the fact that, within comparatively easy distance of six of the nine naval ports in Great Britain and Ireland at which there are naval hospitals, there is a public mental hospital within easy distance, at which doubtless arrangements could easily be made for them to visit and receive clinical instruction. It is not unlikely that our Association in the course of their negotiations with the bodies granting these diplomas might, if desired, be of some assistance in furthering any such movement in the services, more particularly so now that the scope of several of the diplomas has been widened to permit of candidates, whose opportunities in certain of the clinical subjects are small, to show special knowledge in their particular field of work.

Health Visitors.

Passing allusion has already been made to these important workers—the "Mercuries" of our profession—but it would be a matter of self-

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reproach were the brevity of their mention regarded as an index of the utility, as felt by me, of their work. As ancillary to the every-day work of an organised service for the treatment of mental disorders and mental deficiency, and to at least the first two of the four relationships for which establishment has just been pleaded, the value of what can be done by these workers seems insufficiently recognised in their country. They are at present represented, as respects psychological medicine, in connection with the work of the Mental After-care Association, with that of the Central Association for the Care of the Mentally Defective, and with several similar local associations, some of which are affiliated with the Central Association. They should be recognised as indispensable throughout the whole of the scheme of work which it has been my endeavour to outline, and our public mental institutions could do much in promoting arrangements for their requisite training. Multiplicity of visits by this and that health visitor is a mistake and is naturally apt to cause annoyance, but it can be obviated by adequate organisation and sufficiently comprehensive training of each visitor.

Conclusion.

But for the obvious utility of specific reference to and falling in line with the Consultative Council's scheme, my address might perhaps better have taken "Mental Hygiene" as its title; for, indeed, such suggestions as it contains have as their ultimate goal the promotion and preservation of mental health. Even should all these proposals mature, pruned and added to as none better than the Medico-Psychological Association is capable of doing, all the work requisite for that preservation will not have been overtaken. It is therefore of good augury that an idea is afloat to establish in this country a National Committee for Mental Hygiene on the lines of that body of men and women who, under that name, have been for the past thirteen years doing such magnificent work in the United States, and out of whose example similar committees have sprung up in the Dominion of Canada and are contemplated elsewhere in the Dominions, and also, as Dr. Henri Colin of Paris will explain to us,[1] in France.

In concluding these remarks and thanking you for your attention, let me say that no pretence can be made of any of that self-satisfaction which is legitimate in using an opportunity such as this to best advantage. What I have been able to offer you has been put together amidst the exacting pressure of much official work, and consequently my theme, which is undeniably of great importance to all in our sphere of work and deserves leisure to express it in balanced form, may have sometimes seemed to have disappeared beneath its mass of side issue.

May I add that, if here and there some remark has been pitched in

[1] *In his paper on "Mental Hygiene and Prophylaxy."*

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an *ex cathedrâ* or oracular tone, nothing has been further from my desire, which has merely been to offer suggestions. We are all of us engaged in work that embraces some of medicine's greatest difficulties, "things that do almost mock the grasp of thought," and we each owe a duty, when occasion offers, to contribute his share of thought to them. In particular, and in again tendering my thanks for the honourable position in which you have placed me, let me ask you not to read into my remarks any official authority for their utterance. It is the first occasion that a member of the Board to which I have the honour to belong has, while a Commissioner, occupied this chair; and it is my earnest desire that, during my presidential year, nothing I shall say or do may mar the privilege of holding this dual position.

The Problem of the Feeble-minded in South Africa.[1] By J. T. DUNSTON, M.D., B.S.Lond., Commissioner in Mental Disorders for the Union of South Africa.

MR. PRESIDENT AND GENTLEMEN,—To make more clear to you the general position in South Africa as it affects the subject of mental disorders and defects, I propose, if you will allow me, to begin my paper by referring briefly to matters outside its scope as indicated by the title.

Before the Union of the Colonies we had a most excellent Act in force in Cape Colony, passed in 1897. It was taken over practically in its entirety by the Governments of the Transvaal and Free State in 1902 or thereabouts.

When the Union took place in 1910, the enactments in force in each Colony, which had now become a Province in the Union, continued to operate; the need for a consolidating law soon became very apparent, to secure uniformity of procedure, to facilitate the transfer of patients from one institution to another, and to bring all the laws into line with modern legislation, particularly with regard to the care and treatment of the feeble-minded.

There were other urgent needs, the most important of which was the necessity for more accommodation for patients. For many years previous to the Union very little additional accommodation had been provided in Cape Colony. Indeed, it was only in the Transvaal and the Free State that there were beds to spare, but after the Union these were almost immediately filled up by the transfer of patients from the other Provinces. Thus the position became really serious, and patients urgently needing mental hospital treatment were kept in gaols and other unsuitable places for lengthy periods until hospital beds could be allotted to them.

[1] A paper read at the Annual Meeting held in London, July 15th, 1921.