Dr. John Carswell had also examined the prisoner, and gave evidence similar to that of Dr. Hyslop. Three medical officers from Brixton Prison were called by the prosecution to give evidence rebutting the suggestion of insanity. Dr. W. R. K. Watson considered the prisoner to be subnormal, but did not regard him as a certifiable mental defective. Dr. Rixon looked upon the prisoner's desire to wear his best suit at the trial and to have his hair cut as a sign of vanity. The outstanding characteristic of people received into prison on a capital charge was their vanity.

The Judge summed up. No report of this, unfortunately, is available. Faced with the conflict of expert testimony, the jury accepted the evidence given for the defence, and found the prisoner "guilty but insane." He was ordered to be detained " during His Majesty's pleasure."

THE ROYAL COMMISSION ON LUNACY AND MENTAL DISORDER.

Memorandum of the Evidence given on May 4 *and* 5, 1925, *on behalf of the Association to the Royal Commission on Lunacy and Mental Disorder* (*passed by the Association at the Quarterly Meeting, November* 20, 1924). *With Appendices.*

INTRODUCTION.

THE Medico-Psychological Association of Great Britain and Ireland dates back to the year 1841, having for its objects the intercommunication on all matters calculated to improve the care, treatment and recovery of patients suffering from mental disorder, and the collaboration of research into the elucidation of the causes and prevention of insanity. In later years its activities have extended to the education and examination of medical men and women, and nurses engaged in the practice of psychiatry.

The Association consists of between 700 and 800 medical practitioners who are actively interested in the progress of psychiatry throughout the British Empire. The Ordinary or Subscribing Members are mostly medical superintendents or medical officers of mental hospitals, public and private, medical officers under the Prison Commission and county and borough education authorities, professors and lecturers in psychiatry attached to the universities and teaching schools of the Kingdom, and medical men and women in consulting or general practice. The Association has also 14 Corresponding Members living in foreign countries, and 30 Honorary Members. The Association comprises three Divisions for England and Wales, a Division for Scotland, and a Division for Ireland.

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Quarterly general, as well as biennial divisional meetings are held for the discussion of papers, which, with other proceedings, are incorporated in a quarterly publication—*The Journal of Mental Science*. This Journal has existed since the year 1853. The Association has an annually elected President and other Officers of its Council, also a Parliamentary, an Educational, and other Committees. Since 1892 examinations have been held for its Certificate in Psychological Medicine, which has been given to 379 medical men, and at times an Honours Examination has been conducted for the Gaskell Prize. The Certificate of the Association is the forerunner of the Diplomas in Psychological Medicine recently instituted by many of the Universities and Conjoint College Boards. The Association originated, and for many years has actively promoted, the training of mental nurses. Since 1891 examinations have been regularly held for its Certificate in Mental Nursing, which has been awarded to more than eighteen thousand male and female nurses. Since 1917 the Association has also examined nurses for proficiency in training mental defectives, and 193 of such certificates have been granted. The Association is regarded by the medical profession as the leading representative body concerned with psychiatry in this country.

The preparation of evidence to be given on behalf of the Association was entrusted to a Committee consisting of the following members:

*R. H. Cole, M.D., F.R.C.P. (Chairman), Physician for and Lecturer on Mental Diseases, St. Mary's Hospital, London; Examiner in Mental Diseases and Psychology, University of London. Chairman of the Parliamentary Committee of the Association.

W. Brooks Keith, *M.C.*, M.D. (Secretary), Medical Superintendent, St. Audrey's Hospital, Melton, Suffolk. Secretary of the Parliamentary Committee of the Association.

J. Chambers, M.A., M.D., Medical Superintendent, The Priory, Roehampton, London. Treasurer of the Association. Formerly Lecturer on Mental Diseases, Middlesex Hospital, and Co-Editor of the *Journal of Mental Science*.

*M. A. Collins, *O.B.E.*, M.D., Medical Superintendent, Kent County Mental Hospital, Chartham. Former General Secretary of the Association.

R. Eager, *O.B.E.*, M.D., Medical Superintendent, Devon County Mental Hospital, Exminster.

F. H. Edwards, M.D., M.R.C.P., Medical Superintendent, Camberwell House, London.

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*E. Goodall, *C.B.E.*, M.D., F.R.C.P., Physician for Out-Patients in Psychiatry, Cardiff Royal Infirmary; Lecturer on Mental Disorders, Welsh National School of Medicine; Medical Superintendent, Cardiff Mental Hospital, Whitchurch. Former Co-Editor of the *Journal of Mental Science*. Ex-President of the Association.

P. T. Hughes, M.B., Lecturer on Mental Diseases, Birmingham University; Medical Superintendent, Worcester County Mental Hospital, Bromsgrove.

*J. R. Lord, *C.B.E.*, M.B., Medical Superintendent, Horton Mental Hospital, Epsom. Co-Editor of the *Journal of Mental Science*.

E. Mapother, M.D., M.R.C.P., F.R.C.S., Physician and Lecturer for Psychological Medicine, King's College Hospital; Medical Superintendent, The Maudsley Hospital, Denmark Hill, London.

*W. F. Menzies, B.Sc., M.D., F.R.C.P., Medical Superintendent, Stafford County Mental Hospital, Cheddleton. Former President of the Association.

*Sir Frederick W. Mott, *K.B.E.*, LL.D., M.D., F.R.C.P., F.R.S., Consulting Physician, Charing Cross Hospital; Lecturer on Morbid Psychology and Hon. Director of Research, University and City of Birmingham; Examiner in Neurology, University of London; late Pathologist, London County Mental Hospitals. President-Elect of the Association.

Bedford Pierce, M.D., F.R.C.P., Consulting Physician, The Retreat, York. Former President of the Association.

R. C. Stewart, M.R.C.S., Medical Superintendent, Leicester County Mental Hospital, Narborough.

H. Wolseley-Lewis, M.D., F.R.C.S., Medical Superintendent, Kent County Mental Hospital, Barming Heath. Ex-Chairman of the Parliamentary Committee of the Association.

*R. Worth, *O.B.E.*, M.B., Medical Superintendent, Springfield Mental Hospital, Tooting, London. General Secretary of the Association.

* Appointed witnesses.

The Association has for many years been alive to the backward position in many respects of psychiatry in the United Kingdom, and not a few circumstances, such as the apathy and prejudices of the public as regards the insane, reflected in the reluctance of Imperial and local authorities to commit themselves to further expenditure, and the fact that progress in certain directions would require action on the part of the Legislature before it could materialize, have militated against any real advance being made in many matters the Association has very much at heart.

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REPORT OF THE STATUS OF BRITISH PSYCHIATRY COMMITTEE.

This stagnation, although it had received constant attention from the Association, its Council and several Standing Committees, was the subject of inquiry by a special committee appointed in 1911 to consider the "Status of British Psychiatry and of Medical Officers." That Committee took a wide view of their reference, and their Interim Report, published in 1913, set forth in no uncertain manner the grave defects psychiatry laboured under in Great Britain and Ireland. Chief among these were:

(*a*) The absence of proper provision for the early treatment of incipient and undeveloped cases of mental disorder.

(*b*) The few facilities there existed for the study of psychiatry and for research.

That Committee, among other measures, recommended:

That "clinics for mental disorders" in connection with the universities, medical schools and general hospitals should be established.

That as a general principle the admission to all mental institutions should be on a voluntary basis and without loss of civil rights.

That there should be power, if found necessary, to detain for a limited period incipient cases, such being notified to the Board of Control (hereinafterwards called the "Board of Mental Health," vide *Recommendation* 17).

That admissions should be direct into mental institutions, without reference to the Poor Law authorities.

That the use of "urgency orders" (hereinafterwards called "provisional orders," vide *Recommendation* 31) *should be widened.*

REPORT OF THE ENGLISH LUNACY LEGISLATION SUB-COMMITTEE.

With a view to giving effect to some of the recommendations of that Committee, many of which would necessitate emendation of the existing Lunacy Acts, the Association in 1918 appointed the "English Lunacy Legislation Sub-Committee," which reported late in the same year.

That Report has had a wide circulation amongst the authorities concerned, and in the light of reconsideration after a lapse of six years is found to require but slight emendation. The Report was published in order to promote a Bill to facilitate the temporary treatment of incipient mental disorders without certification. The

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main principles in the Report involved the establishment of psychiatric clinics, associated wherever possible with general hospitals, the admission of voluntary boarders (hereinafterwards called voluntary patients) to be extended to rate-supported mental hospitals, and the recognition of the need of further provision for paying patients. These principles, and other supplementary proposals, were generally accepted, and in the main are to be found incorporated in the Mental Treatment Bill of 1923 (with provision for after-care and research). This Bill, for reasons which were not political, failed to reach the Statute Book.

THE EXISTING LUNACY ACTS.

The Association is of opinion that the vast majority of the community, including patients, is grateful for the protection afforded by the existing Lunacy Acts, and that the safeguards they provide against abuses and illegal detention have on the whole proved satisfactory.

These Acts have, however, failed to keep pace with medical progress, especially in regard to the treatment of the initial and more curable stage of mental disorders.

The Association, therefore, welcomed the appointment of a Royal Commission on Lunacy and Mental Disorders as an opportunity of stating its views in regard to amendment of the Lunacy Acts for England and Wales and, more especially, the principles involved in the reception, treatment, care and discharge of patients in institutions, and hopes that the Royal Commission will impress upon the Government the necessity of proceeding with a Mental Treatment Bill in harmony with the aspirations of the Association as set forth in this memorandum.

THE STATUS AND EDUCATION OF MEDICAL OFFICERS AND NURSES.

The Association notes with satisfaction that an increasing number of medical officers are granted study-leave, and obtain diplomas in psychological medicine, and that a large number of mental nurses now hold the Certificate in Mental Nursing of the Association.

SUMMARY OF RECOMMENDATIONS.

It is convenient here, before proceeding to set forth *in extenso* the Association's recommendations, to summarize the chief guiding principles upon which they are based.

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The Association is of the opinion:

That "clinics for mental disorders," preferably in connection with the universities, medical schools and general hospitals, should be established.

That the reception into mental institutions of patients, whether of the private (hereinafterwards called "paying patients") or of the pauper (hereinafterwards called "rate-aided patients") class, should follow a similar procedure.

That a considerable proportion of admissions to mental institutions should be dealt with on a voluntary basis, so that such voluntary treatment should be extended to the rate-aided class, for which legislative sanction has already established precedents at the Maudsley Hospital and at the City of London Mental Hospital.

That special legal machinery should be devised for treating early non-volitional cases.

That a "provisional order" should be instituted as an intermediary measure before the usual "judicial order" for detention is enforced.

That when such detention is necessary for the cure or care of patients, medical certification should take place as constituting evidence, but that the authority for detention, discharge and continuation, i.e., *renewal) of orders should entail the responsibility of some authorized person not acting in a medical capacity.*

That a broader conception should be taken of the functions of both the central and local authorities for "lunacy" or mental health administration.

That the Poor Law authorities should be superseded by the local authorities in regard to the care, treatment and maintenance of necessitous patients suffering from mental disorders.

SUMMARY OF MATTERS OF FACT.

1. There are very few facilities for patients who are threatened with mental breakdown to obtain skilled treatment. As a rule they do not obtain it until certification takes place. But early symptoms of disorder often occur long before certification is possible.

2. Owing to efficient treatment being delayed the most valuable time for adopting measures to secure early recovery is lost.

3. There is strong objection to certification in itself on the part of the public, which is alive to the material and moral damage that it so often inflicts on the patient and his relatives, so that even when certification has become possible they refuse to resort to it, and thus still further postpone the adoption of efficient treatment.

4. In cases where certification has to be resorted to, the subse-

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quent course of events often shows that this might have been avoided with advantage if there had been facilities for treatment under other conditions.

5. The experience gathered as the result of the war has opened the eyes of the public and the medical profession in a fresh way to the difficulties and needs of these cases.

6. Many medical practitioners, having had no opportunity of gaining knowledge of the manifestations and treatment of mental disorders in their early stages, fail to recognize the seriousness of the condition and to secure for their patients efficient treatment. They are also often deterred, by the necessity of certifying the patient, from advising suitable treatment. This unwillingness may be due to a genuine and proper doubt whether the condition is sufficiently definite to justify this procedure or to a natural reluctance to cause distress to the patient and his friends. In some cases direct evidence of insanity cannot be obtained at any particular interview, and certification and treatment are thus delayed.

7. In many early cases advantage would be taken of the opportunity for treatment were the voluntary patient system, with some modification of procedure, extended to rate-supported mental hospitals.

8. Many persons of the well-to-do classes, who are the subjects of mental disorder and are certifiable, are now placed in private houses and nursing homes without an order having been obtained for their reception. No intimation of their admission is given to the Board of Mental Health. No precautions are necessarily taken to ascertain that the conditions are favourable for the patient, or that efficient treatment is thus being obtained for him. It is felt that while many cases may be treated in private houses and nursing homes quite properly, provision should be made to give the competent authority the opportunity of ascertaining that houses and homes in which such patients are received are suitable for the purpose, and that the persons in charge are competent to treat cases of mental disorder.

RECOMMENDATIONS.

Recommendations 1 *to* 15, 24, 25, 41, 44, 51 *and* 53 *were made by the English Legislation Sub-Committee of the Association, and with some emendations have again been adopted.*

Recommendations 16 *to* 23, 26 *to* 40, 42, 43, 45 *to* 50, 52, *and* 54 *to* 58 *are the outcome of the more recent deliberations of the Special Committee appointed to prepare this memorandum (see page* 2*), the*

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Parliamentary Committee and the Council, and were adopted at a General Meeting of the Association held on November 20, 1924.

Recommendation 1: The Association considers that the opportunity is afforded now for a further revision of the Lunacy Acts for England and Wales.

Although some desire to see the Lunacy Acts entirely re-cast, with abolition of the justice's order and other legal formalities, the majority are satisfied that such far-reaching changes are not expedient, and that the reforms most urgently needed could be obtained by an Amending Bill.

As the Association cannot but think that all, with experience of the subject, agree that the Law now presses hardly on certain cases, rate-aided and paying alike, is not abreast of modern requirements and aspirations, and is not working in the best interests of the State, it has endeavoured to frame proposals to meet these defects.

In doing so, it has kept in mind on the one hand the practical convenience and view-point and possible prejudice of those for whose benefit the measures suggested are intended, and on the other the necessity of winning the support of instructed lay opinion, the medical profession and the constituted authorities.

Psychiatric Clinics and Research Laboratories.

Recommendation 2: That clinics be established by local authorities for the treatment of nervous and mental diseases in their early stages; and that in the organization of clinics special provision be made for children.

Recommendation 3: That voluntary patients should be received and also that provision be made for the reception of non-volitional patients for a limited time without certification in such a psychiatric clinic. (*Vide* Recommendation 58 (*a*) (*c*).)

Recommendation 4: That such a clinic should be where possible an annexe to a general hospital or housed in a special building.

Recommendation 5: That such a clinic should be adequately staffed and the medical and nursing personnel should include special staff trained in psychiatric work.

Recommendation 6: That it should be the duty of local authorities to provide and maintain clinics either themselves or by arrangement with voluntary organizations for the purpose (*vide* Recommendation 58 (*a*)).

Recommendation 7: That the supervisory committee or committee of management of such a clinic should be a special committee of the local statutory committee of mental health.

Recommendation 8: That the inspection and approval of the

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buildings used for such clinics should be the duty of the central Government department. (For definition see Recommendations 16 and 17.)

Recommendation 9: That it is desirable that neighbouring mental hospitals should be enabled to establish and maintain joint laboratories for research (*vide* Recommendation 58 (*a*)).

Psychiatrical clinics aim at providing facilities for treatment of which ailing members of the public will be ready to avail themselves at the earliest possible moment, even when the condition is merely what is commonly described as one of "disordered nerves." This necessitates as complete a dissociation as possible from the existing statutory requirements for dealing with the insane.

It also necessitates the provision of facilities similar in character and equal in completeness to those available for purely physical ailments—that is, a thoroughly well-found and well-staffed clinic for both in-patients and out-patients. These facilities must be brought as near to the homes of the people as possible. They should therefore be established all over the country in large centres of population, preferably in connection with general hospitals, so that the people may easily obtain treatment or seek advice and so be encouraged to obtain instruction in mental hygiene at a stage when preventive measures are possible, and thus escape in many cases a serious breakdown, to the advantage both of themselves and the community; for thus would be retained as workers those who otherwise become a burden to their fellows.

No mere extension of the voluntary patient system in the mental hospitals (which is much to be desired on other grounds) would meet these requirements. Nor is it probable that any arrangements that might be made with general hospitals throughout the country would alone be sufficient.

Just as in ordinary hospitals some cases of delirium and excitement with loss of control occasionally occur and are dealt with without any great difficulty, so similarly cases of mental disease in their early stages where the symptoms are likely to subside under proper treatment would be received and suitably provided for in the proposed clinics.

The decision whether a case is or is not suitable for treatment in such a clinic would depend upon practical convenience and the nature and duration of the symptoms.

In large towns clinics should be part of, or annexes of, or failing these, affiliated to, the general hospitals for many important reasons (*vide* Appendices I and II), not least among them being that students may have opportunities of studying those early stages of mental disorder which as practitioners they will be called upon to treat.

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Nurses undergoing hospital training could also take advantage of these opportunities to aquire a general knowledge of mental cases.

Clinics would also provide a valuable field for post-graduate work and for scientific research with the necessary laboratory accommodation.

Special clinics to act as "clearing houses" may be necessary in large districts, but it is hoped that if the bulk of the occurring mental disorder were overtaken while in its early stages, such "clearing houses" would be a disappearing factor in the mental health service of the country. Admission of suitable cases direct to mental hospitals is part of the policy of the Association.

As the Association is anxious to emphasize the necessity for the establishment of psychiatric clinics and research laboratories by local authorities, further detailed evidence on this important matter will be found in Appendices I and II.

Voluntary Patients in Mental Hospitals.

Recommendation 10: That mental hospitals should be encouraged to admit persons as voluntary patients without loss of civil rights on their signing an application to that effect addressed to the medical officer of the institution, provided:

(*a*) That there is accommodation approved of by the central Government department and the applicants are suitable persons.

(*b*) That they should be required to give 72 hours' notice in writing of their desire to leave the institution, after the expiry of which period they must cease to reside as such; further provided that, before the notice expires, the patient does not intimate in writing his desire to withdraw the notice.

Recommendation 11: That regulations should be made setting out the conditions on which the medical officer may admit voluntary patients.

Under the present Lunacy Acts voluntary patients may be received in registered hospitals and licensed houses. This facility should be extended to suitable persons, whether of the paying or rate-aided class, desirous of placing themselves under treatment in the county or borough mental hospitals.

Many patients who have recovered in a rate-supported mental hospital from a previous attack, and are on the verge of a relapse, wish to place themselves under mental hospital care again, but are, at present, unable to do so until they become certifiably insane, and then they must be referred to the relieving officer.

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There will no doubt be other cases unable to afford the expense of a registered hospital or licensed house who will prefer to apply direct to a rate-supported mental hospital for treatment in the first instance, if they can do so under the conditions attaching to voluntary patients. Their admission thereto would depend upon their suitability.

The Board of Mental Health should be informed of all persons received as voluntary patients into mental hospitals, but their previous consent thereto, or that of the justices in the case of the licensed houses, seems unnecessary and interferes with the utility of the plan, as many patients object to making written application to the Board of Mental Health or the justices for permission, as at present required; moreover, no such requirement obtains in the case of the registered hospitals.

Further, there appears to be no good reason why this mode of admission should be reserved for persons who cannot be certified as insane, as it conflicts with the fundamental principle that treatment should be begun at the earliest possible moment. It should be sufficient for anyone, being aware of his mental illness, voluntarily to sign a document expressing his desire to be admitted as a voluntary patient to a mental hospital for purposes of treatment.

For practical convenience it is much to be desired that the notice required to be given by voluntary patients of their intention to leave should be increased from 24 to 72 hours.

The reform suggested has long been advocated, and has met with practically no opposition.

Further Provision for Paying Patients.

Recommendation 12: That the central Government department should have power (*a*) to approve homes which are supported wholly or partly by voluntary contributions or which are privately owned, in which it shall be lawful to receive without certification more than one paying patient suffering from mental disease in its early stages, and (*b*) to give legal sanction to the reception without certification of such patients as single patients in houses not so approved, provided that a medical practitioner gives a written recommendation in each case, stating that suitable treatment can be obtained for the patient in the proposed house.

Recommendation 13: That on any such patient being received into or ceasing to reside in any approved (or recognized) home, or as a single patient in a house not so approved, the fact shall be intimated to the central Government department.

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Recommendation 14: That it should be possible to transfer the jurisdiction for licensing a house from one authority to another on good reason being shown.

Recommendation 15: That certified patients and voluntary patients should be permitted reception direct to the branch establishments of registered hospitals and licensed houses.

It has to be recognized that the objection to certification in the early and curable stages of mental disorder is strongly felt by all classes, and the temptation, for those who can afford it, to send patients to unrecognized places of treatment is very great both for the patient's friends and their medical advisers. Those who receive such patients knowingly run the risk of prosecution, and there is no guarantee that they can or do give suitable care or treatment to the patients. The treatment of certain cases of mental disorder in suitable private houses and nursing homes is undoubtedly desirable, and the true interests of the patients should be obtainable in conformity with the law.

Where residential treatment is conducted for payment in the case of patients suffering from mental disorder which is deemed to be temporary, but who may be considered certifiable, it is desirable that the fact of their reception should be brought to the cognizance of the central authority. It is hoped that with this safeguard facilities may be granted for the treatment for payment by private persons or voluntary associations of early, undeveloped and recoverable cases of mental disease without the drawbacks attaching to certification.

It is suggested that the Board of Mental Health should be empowered to give legal sanction to the treatment of this group of cases without certification. This can only be done by provisions limiting the application of Section 315 of the Lunacy Act, 1890, which imposes penalties on those receiving persons of unsound mind for payment without certification. It is not proposed to do away with this Section, and as its enforcement is in the hands of the Board of Mental Health, it is practically necessary to give any powers overriding its application to the same body.

The Central Authority.

Recommendation 16: That all matters of mental health be centralized in the Board of Control as the Government department under the Minister of Health and Lord Chancellor.

Recommendation 17: That such Government department or central authority be designated the "Board of Mental Health," instead of the present term "Board of Control," and that such Board should be increased in its medical *personnel*.

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Recommendation 18: That at the statutory visits made to all mental institutions, public and private, and to patients in single care, one at least of the commissioners of the Board of Mental Health should be a medical commissioner.

Recommendation 19: That in making appointments of Medical Commissioners of the Board of Mental Health, it is important to take into consideration not only experience in mental disorders, but also experience in general medicine, and status in the medical profession.

Recommendation 20: That the remuneration of the medical members of the Board of Mental Health should be increased. The State should require the medical members of the Board to be of the highest standard of scientific and professional attainments.

The Local Authority.

Recommendation 21: That the management of all rate-supported institutions for the care and treatment of mental disorders and mental defect be vested in one statutory committee of mental health of a local authority.

Recommendation 22: That the statutory committee should direct all matters relating to mental health in the area, having regard to both voluntary and certified patients in rate-aided institutions, whether in clinics, mental hospitals, or elsewhere.

Recommendation 23: That the county or borough rate be utilized to support the maintenance of necessitous patients as well as that of the fabric of public mental institutions, and that such rate be supplemented by a Government grant, payable upon the certificate of the Board of Mental Health, which grant should extend to the provision for research, special medical and nursing training, and after-care.

Legal Formalities, etc.

Recommendation 24: That the existing Lunacy Acts should be called the Mental Disorders Acts, and an amending Act the Mental Treatment Act.

Recommendation 25: (*a*) That the words "lunacy" and "lunatics" be discontinued and the words "mental disorders" and "persons of unsound mind" be substituted.

(*b*) That instead of the word "asylum" the words "mental hospital" be used—county, city, or borough, as may be.

(*c*) That the word "rate-aided" be used instead of the word "pauper."

Recommendation 26: That patients who need care and treat-

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ment for mental disease at the public expense should not, on that account, be termed, or be regarded as, paupers.

Recommendation 27: That in-patient voluntary treatment be legalized in rate-supported mental hospitals as well as in clinics, and that the maintenance charges in necessitous cases be defrayed out of public funds by the statutory committee.

Recommendation 28: That rate-aided patients requiring certification be afforded similar procedure as obtains with paying patients, *viz.*, the protection of *two* medical certificates on petition for a judicial reception order, instead of a summary reception order on one certificate which is the usual practice at present.

Recommendation 29: That when a relative or friend of a rate-aided patient is unable or unwilling to act as petitioner, an officer of the local authority, or other suitable officer, may be the petitioner entrusted with the duties of carrying out the requisite formalities.

Recommendation 30: That it should be made possible for rate-aided patients as well as paying patients to be admitted to mental hospitals under a "provisional order" (*vide* Recommendation 31–35).

Recommendation 31: That the present system of urgency procedure for all unwilling patients might with advantage be superseded by the institution of a provisional order.

Recommendation 32: That a provisional order may be used not only on the ground of urgency, but so as to provide means of temporary care, observation and treatment under safe conditions.

Recommendation 33: That a provisional order with statement of particulars should be signed by a relative or friend, or by an officer of the local authority, authorizing the reception of a patient for temporary care, observation and treatment.

Recommendation 34: That a provisional order should be accompanied by a medical certificate in special form, specifying facts and reasons indicating that a patient is a proper person for temporary care, observation and treatment.

Recommendation 35: That a provisional order and certificate should last three days, but be capable of extension in suitable cases for a further period not exceeding twenty-eight days, provided such extension is sanctioned by a judicial authority, or by two members of the visiting committee of a public mental institution, who may direct a further examination by another medical practitioner.

Recommendation 36: That when a provisional order and certificate is about to expire, the following three courses should

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be considered, according to the exigencies of the case, namely: (*a*) that the patient be discharged; (*b*) that the patient may remain voluntarily, or be dealt with, if a non-volitional case, under some such procedure as that projected in Section 4 of the Mental Treatment Bill, 1923; (*c*) that a judicial reception order for detention be obtained on petition with two medical certificates.

Recommendation 37: That verbal alterations in the present form of petition for a reception order are desirable, *viz.*, the deletion of the words "lunacy" and "lunatic or idiot" in the margin; the substitution of "mental hospital" for "asylum," and "provisional order" for "urgency order"; and in the statement of particulars accompanying a petition or provisional order, the substitution of "whether previous history of mental disorder" for "whether first attack," "age at the onset of mental disorder" for "age on first attack," "when and where previously under care and treatment for mental disorder" for "when and where previously under care and treatment as a lunatic, idiot, or person of unsound mind," "duration of present mental disorder" for "duration of existing attack," and the addition of questions as to the length of residence at present address if such is not the usual place of abode, and as to the maiden name of a patient who is a married woman or widow.

Recommendation 38: That in the medical certificates (Form 8) used on petition, the words "separately from any other practitioner" be deleted as also in Section 29 (2) of the Lunacy Act, 1890; that a lettered space be inserted for "facts observed by the medical practitioner on previous occasions," and an additional lettered space giving his reasons for the necessity of detention.

Recommendation 39: That in the reception orders (Forms 3, 4, 12, 15) the words "authorize (direct) you to receive and detain" be substituted for "authorize (direct) you to receive."

Recommendation 40: That it is desirable that a judicial reception order should be made by a justice specially appointed in all cases, and who has seen the patient, and that the difficulties of procuring the services of a justice in certain areas should be remedied.

Recommendation 41: That where no criminal offence is charged it is undesirable that justices should in court conduct the examination of mental cases for the purpose of making reception orders.

Recommendation 42: That the present special report and certificate required to continue a reception order at stated intervals should be countersigned by a judicial authority, or

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two members of the visiting committee of a public mental hospital, and that the latest date of signature should be the end of the existing quarter in which the special report falls due.

Recommendation 43: That a copy of such special report and certificate thus countersigned be accessible to a discharged patient, on appeal to the Board of Mental Health, as in the case of the original reception document.

Recommendation 44: (*a*) That there is much need of simplification of forms under the existing Lunacy Acts.

(*b*) That intervals in time require uniformity and where convenient should be defined in hours.

(*c*) That the duration and lapsing of "reception orders" require amendment.

Recommendation 45: That leave of absence on trial or for health should be encouraged, and that no ambiguity should occur to prevent the return at any time of a certified patient to the institution or house if the petitioner or medical officer deems such return expedient.

Recommendation 46: That the discharge of rate-aided certified patients should, as in the case of certified private patients, be vested in the petitioner, but that in the former case six days' notice in writing should be given to the medical officer of a rate-supported mental hospital by the petitioner, desiring the discharge of a patient, and that if the medical officer considers that it is not in the interest of the patient or of the public that the patient should be discharged, he should then be permitted to defer the matter for the decision of the visiting committee at its next meeting, which shall have power to over-ride the action of the petitioner.

Recommendation 47: That the existing restriction of discharge of a patient by the certificate of a medical officer under Section 74 of the Lunacy Act, 1890, should be countersigned by a judicial authority or by two members of the visiting committee of a public mental hospital.

Recommendation 48: That Section 75 of the Lunacy Act, 1890, which deals with discharge by two commissioners, and Section 83 which deals with discharge on recovery, be extended to include rate-aided patients in mental hospitals.

Recommendation 49: That the automatic discharge of a patient by escape after fourteen days is undesirable.

After-care.

Recommendation 50: That the after-care of rate-aided patients should receive due attention, and that the work done

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by The Mental After-Care Association, or other bodies appointed to deal with after-care, should receive adequate pecuniary recognition by statutory committees.

Poor Law Infirmaries.

Recommendation 51: That it is undesirable that patients alleged to be of unsound mind should be removed to a workhouse or pauper infirmary before their reception in a mental hospital. If an intermediary stage is necessary after the provision of clinics for incipient cases it would be better supplied by a special clinic under the management of the local authority. Practical convenience such as a motor service should be available for the transfer of patients to mental institutions on lines similar to those adopted in the Public Health Service.

Recommendation 52: That a Poor Law infirmary may be regarded as an institution for mental disorders if approved by the Board of Mental Health.

Recommendation 53: That it should be permissible for patients transferred from a mental hospital to a Poor Law institution to be transferred back without re-certification.

Recommendation 54: That the present certificate of a medical officer of a Poor Law infirmary should not as in Section 24 (2) of the Lunacy Act of 1890 be sufficient authority for the detention of a patient for fourteen days, but should require the addition of a provisional order.

Recommendation 55: That reports on mental cases in all Poor Law institutions, as in mental hospitals, should be notified to the Board of Mental Health, and that the arrangements provided for mental cases should be under the management of the statutory committee of mental health of the local authority.

Recommendation 56: That better provision should be made for the care and treatment of senile cases in infirmaries approved by the Board of Mental Health, in order that every effort should be made to avoid the stigma of certification.

Protection to Medical Practitioners and Others.

Recommendation 57: That the protection afforded by Section 330 of the Lunacy Act, 1890, to medical practitioners, and to others engaged in pursuance of the Act, should be extended to stay proceedings at an earlier stage than at present, and that they should receive the same immunity as is given to witnesses in a court of law.

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Mental Treatment Bill, 1923.

Recommendation 58: In the event of the Mental Treatment Bill, 1923, as amended by the House of Lords, being again introduced to Parliament, the Association will press for emendation on the following lines:

(*a*) Section 2: Subsections (2) and (3) should be obligatory as regards provision of institutions in accordance with Recommendation 6. That the term "institution" should be defined within the meaning of "approved institution" under Section 4 (2). That "voluntary patient" should be substituted for "boarder" in Subsection (3), and that there should be no legal formality necessitating the written application of a voluntary patient for reception to a public mental clinic. That a further Subsection is desirable dealing with voluntary patients in private houses and nursing homes in accordance with Recommendations 12 and 13. That in addition to research in Subsection (5) the expenses of special medical and nursing training should be included in accordance with Recommendation 23.

(*b*) Section 3: The Association regards both subsections as opposed to Recommendations 16 to 20.

(*c*) Section 4: The Association desires that voluntary patients should be dealt with under Section 2, and that Section 4 should deal only with non-volitional patients, and minors. That extensions for treatment should be permissible for further periods of six months. That this Section should also apply to non-volitional patients, and minors in private houses and nursing homes. That one recommendation from any medical practitioner should be required. That notification to the Board of Mental Health within 24 hours of reception should be a sufficient safeguard, and render an annexed statement by a justice or minister of religion unnecessary.

(*d*) Section 5: The Association considers that this Section requires redrafting to distinguish discharge of voluntary patients from non-volitional patients, and minors, and that notice of leaving should be in writing.

OFFICE OF THE ASSOCIATION,
11, CHANDOS STREET,
CAVENDISH SQUARE, W. 1;
January, 1925.

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APPENDICES.

These appendices were not submitted to the Association and are not therefore included in the approval given by the Association on November 20th, 1924. They have the general approval of the witnesses appointed to represent the Association before the Commission.

APPENDIX I.

PRÉCIS OF EVIDENCE

ON THE

NEED FOR BETTER PROVISION FOR EARLY TREATMENT OF MENTAL DISORDERS, AND FOR PSYCHIATRIC EDUCATION AND RESEARCH.

By Brevet Lt.-Col. Sir FREDERICK MOTT, *K.B.E.*, F.R.S., LL.D., M.D., F.R.C.P.

I represent, with others, the Medico-Psychological Association of Great Britain and Ireland, of which I am President-Elect.

I am Consulting Physician to Charing Cross Hospital, having, prior to the war, had thirty years' experience of general medicine.

During the war I was Neurological Expert to the War Office, and was Medical Director of the Maudsley Neurological Clearing Hospital.

For twenty-eight years I was Pathologist to the London County Mental Hospitals and Director of the Pathological Laboratory for Research. I now hold the post of Hon. Director of the Course of Psychological Medicine at the Maudsley Hospital.

I am, at present, Lecturer on Morbid Psychology to the University of Birmingham, and Hon. Director of Research to the Conjoint Board of the Corporation of the City and the University of Birmingham.

I am Examiner in Psychological Medicine to the Conjoint Board of the Royal Colleges of Physicians and Surgeons, and during the last four years I have been Examiner at the London University. I have held Examinerships in physiology, pathology and medicine at various universities and to the Royal Colleges.

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During the last thirty-five years I have been engaged in the practical study of pathology in relation to general medicine, and especially in its relation to the causation and treatment of nervous and mental diseases.

The evidence which I am desirous of submitting falls under the three following headings:

(1) Early Treatment. (2) Psychiatric Education. (3) Psychiatric Research.

EARLY TREATMENT.

At the present time the insane are, owing to their antisocial tendencies or conduct, segregated, with few exceptions, in huge institutions as a matter of economy; these are now for the most part known as county and borough mental hospitals; unfortunately in the majority of instances the name alone has been changed, for, excepting in the newer asylums, no separate buildings and clinical laboratories for the diagnosis and treatment of recent recoverable cases have been provided. This mixing of acute and possibly recoverable cases with the chronic incurable is now being recognized as a thoroughly bad system, for it tends to create ideas of hopelessness in recent admissions and not infrequently of helpless despair of returning to their homes. The same feeling of despair tends to exist among those who, in these large institutions, have the care and treatment of patients whose chronic mental disorder has often resulted from neglect of medical aid in the early stages of the disease.

We may well turn, therefore, to what Francis Bacon said regarding supposed incurable diseases:

"A work therefore is wanting upon the cures of reputed incurable diseases, that physicians of eminence and resolution may be encouraged and excited to pursue this matter, as far as the nature of things will permit, since to pronounce disease incurable"—and I would add unpreventable—"is to establish negligence and carelessness as it were, by a law, and screen ignorance from reproach."

I will support this statement by a passage from "A Mental Hospital, its Aims and Uses" (*Archives of Neurology and Psychiatry*, vol. iv), by the late Dr. Henry Maudsley, who backed his opinion, during his lifetime, by giving £30,000 to the London County Council to build a hospital for early treatment, education and research.

"That there are crowds of incurable cases of insanity congregated in large asylums is undoubtedly owing in some measure to the common neglect of early treatment when the malady is most curable. The longer the disease has lasted, the smaller are the chances of recovery; and the time soon comes in some cases when, if neglected, there is no remedy. Here, as everywhere, the right treatment is to stop the beginnings of mischief. It may be reasonably expected, therefore, that besides the prevention of incipient insanity by wise counsel and treatment in its out-patients' department, the early treatment of acute insanity in a special hospital will prevent the present necessity and perhaps lasting expense of placing

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some patients in a lunatic asylum—the very name of which is perhaps a terror, the remembrance a sort of nightmare, and the social consequences a life-long prejudice."

Every effort should therefore be made to induce the patient, the friends and the practitioner to seek skilled advice or treatment with as little delay as possible. This can only occur if the fear of certification and of being sent to an asylum be removed, and by the provision of greatly increased facilities for early treatment in clinics attached to the general hospitals or suitable hospitals affiliated with the general hospitals.

That there is a great lack of facilities for early treatment of mental and nervous disorders is generally admitted, and the question arises, *How can this lack be overcome in the most economical and efficient manner?* The following suggestions for early treatment have been made:

(1) The establishment of hospitals on the lines of the Maudsley Hospital—a recognized institution for the care and treatment, without certification, of early cases of mental disease and of functional neuroses, in close connection with King's College Hospital, and a recognized school of the London University. An ideal scheme, but it could only be carried out by a City or County Council with a large population—*e.g.*, Birmingham might establish such a "Mental Hospital" in association with either of the two great general hospitals in that city, and affiliated as a school of the University; or a group of authorities representing boroughs and county councils in the Midlands might combine with Birmingham for this purpose.

(2) The establishment of psychopathic clinics, efficiently staffed and equipped with wards or beds at general hospitals, the financing of this clinic being based upon the lines adopted for tuberculosis and V.D. clinics.

(3) The establishment of hospitals associated with, but outside the grounds of existing asylums, provided with properly equipped and staffed clinical laboratories under borough or county councils, and, where possible, affiliated with a general hospital, a medical school or a university.

(4) That the present system of admission of early cases of mental disorder into Poor Law infirmaries should be discountenanced unless the provision for care and treatment of such cases has been approved by high authority. Especially does this approval apply if the time of detention be extended, as has been recommended.

There is a great advantage in the closer association of rate-aided institutions with general hospitals for the services of specialists, *e.g.*, pathologists, ophthalmologists, gynæcologists, ear, nose and

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throat specialists, radiologists and dentists could be obtained. In fact, the more we link up the treatment of mental disorders and diseases with bodily disorders and diseases, the more will the influence of mind on body and body on mind be apparent, and help towards a rational solution of this great problem concerning mental health.

PSYCHIATRIC EDUCATION.

Sir George Newman, in an admirable report, *Some Notes on Medical Education*, in 1918, stated:

"It is deplorable that the English student of medicine should have no opportunity of learning modern methods of psychiatry, or of diagnosing incipient and undeveloped cases of mental disease."

Again in 1923, the same author in *Recent Advances in Medical Education in England* points out how necessary it is for the general practitioner to have been taught as a student the subjects of psychology and psychopathology. He states that—

"The general practitioner stands in somewhat peculiar need of knowledge of mental conditions. He must first know the normal mind, then the signs of true mental deficiency, and lastly, the various forms of mental disease. His need in these respects becomes obvious to him at the onset of practice, for mental factors play a part in almost every case of illness. . . . Yet at present we teach the student nothing of the make-up of the normal mind . . ."

Sir George Newman shows how necessary this instruction is to the practitioner in the following passage:

"He must be equipped for miscellaneous medical practice and emergencies, and he must be competent to diagnose all the chief forms of mental disease and defect (Lunacy Act, 1890, Mental Deficiency Act, 1913, Elementary Education (Defective and Epileptic Children) Acts 1899 and 1914). The certificates under these Acts necessitate a diagnosis, a record of the clinical grounds for it, and in some cases the medical reasons for detention or custodial care."

The war has shown the great need of systematic teaching of psychological medicine as part of the medical curriculum. In 1907, in the preface to vol. iii, *Archives of Neurology and Psychiatry*, I strongly advocated this teaching for post-graduates, and suggested that a diploma of psychological medicine should be instituted, for I felt sure that it would raise the tone of the medical men employed in the care of the insane, and lead to a better diagnosis and treatment of mental disease in the early curable stage. I also advocated the establishment of a psychiatrical clinic in London, where incipient and borderland cases could be seen and treated. I was convinced in 1907 that the institution of a diploma in psychological medicine would prove as valuable as the diploma of public health, and I called upon the President of the Royal College of Physicians to try to induce the Royal Colleges to give such a

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diploma, but I was quite unsuccessful. In October, 1908, the Medico-Psychological Association appointed a Post-Graduate and Diploma in Psychological Medicine Committee, and in January, 1910, circulated among all universities, medical schools and examining bodies its model regulations and curriculum for a diploma in psychological medicine. These have recently been revised and re-issued. Just prior to the war Cambridge University led the way and instituted such a diploma, and now many universities and the Royal Colleges give diplomas of psychological medicine. The systematic teaching of psychological medicine has been in operation now for four years at the Maudsley Hospital. Seven courses have been completed, and the eighth course has commenced in January. These classes have been well attended, and a large number of those graduates and medical officers who have attended the courses of instruction have obtained a diploma in psychological medicine.(1) This has produced a new spirit among the medical officers of the London County Mental Hospitals—a spirit fostered, I am pleased to say, by the Mental Hospitals Committee of the London County Council; moreover, the possession of the diploma is becoming indispensable for senior appointments, and it is more and more being recognized that administrative capacity is not the only qualification necessary for the posts of medical superintendent and of a senior medical officer.

It is not only medical officers who require training, but also all those engaged in the care and treatment of the insane and in their after-care. The former has for a long time been carried out by the Medico-Psychological Association. "Before care" is even more important, *i.e.* public mental hygiene, and particularly the recognition of the importance of habit formations in childhood and early adolescence. The psychopathic clinics at the general hospitals will do much to educate the public in mental hygiene.

PSYCHIATRIC RESEARCH.

It is only by psychological, sociological and biological research that we can hope to ascertain the causes and contributory factors of mental disorders, their prevention and their remedial treatment. When I was appointed Pathologist to the London County Council to investigate the causes of mental disorders, I insisted upon the necessity of retaining my association with a general hospital. I found this of the very greatest value in relation to the study of alcohol and insanity, syphilis as a cause of mental disease, the reproductive organs and the ductless glands and their relation to certain

(1) A synopsis of these courses of instruction was handed in.

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types of mental disease, and the influence of chronic microbial infections as a cause or an important contributory factor of mental disease.

Syphilis as a cause of general paralysis was not mentioned in the asylum reports. Prevention and early treatment, I am confident, will see not only this disease rapidly decline, but cases of organic brain disease, dementia, imbecility and idiocy will likewise diminish in numbers.

Severe epidemics of dysentery were frequent in the London asylums and the patients were said to die of ulcerative colitis, for there was a prevalent idea that the disease was due to the mental affection. I was able to show that it was an infectious disease, and could be prevented by isolation and sanitary measures. I have seen patients die of this disease within a short time of admission, and certainly if a patient recovers, a serious bodily disease such as this must militate against early recovery from the mental disease.

Not only from a medical point of view but from an economic point of view should scientific research be developed and encouraged. In my judgment research would be most satisfactorily carried out by the provision of a central laboratory in association with a university for a group of asylums. This laboratory should have a director and an efficient and adequately paid staff, which should collaborate with the asylums of the group, and, if necessary, undertake skilled routine laboratory investigations which could not be efficiently undertaken in the clinical laboratories of the asylums. The director should promote and advise research in the asylums of the group and afford help when necessary. The director and his staff should undertake systematic researches in collaboration with the medical superintendents and the medical officers, but should retain an independent position. The central laboratory should be equipped with the necessary rooms and appliances for physiological, psychological, histological, bacteriological, biochemical and psycho-physical investigations.

Such a central laboratory for the London County Council Mental Hospitals exists at the Maudsley Hospital and at Cardiff. A Joint Board of Research of the University and Corporation of the City of Birmingham has been established with a well-equipped central laboratory, of which I am at present the Honorary Director. It is hoped that this may extend its usefulness in promoting research by the incorporation of a number of the Midland asylums. Those asylums which contribute to the maintenance of the laboratory would have a representative on the Board of Research.

In conclusion I may say I have visited many of the psychopathic hospitals on the Continent and in the United States.

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APPENDIX II.

PRÉCIS OF EVIDENCE

ON THE

LACK OF FACILITIES FOR EARLY TREATMENT OF MENTAL AND ALLIED DISORDERS IN ENGLAND AND WALES, AND FOR SCIENTIFIC INVESTIGATION IN RESPECT OF CAUSATION, PREVENTION AND TREATMENT.

By Lieut.-Col. E. GOODALL, *C.B.E.*, M.D., B.S., F.R.C.P., M.R.C.S.

I represent, with others, the Medico-Psychological Association of Great Britain and Ireland.

I am Medical Superintendent of the Cardiff City Mental Hospital, having occupied this post since 1906, *the hospital opening in* 1908.

I was in charge of this institution—then known as the Welsh Metropolitan War Hospital—during the War. One-half the hospital was, for a considerable time, used for neuro-psychiatric cases amongst the troops.

I am Lecturer on Mental Disorders, Welsh National School of Medicine; Physician for Out-Patients in Psychiatry, Cardiff Royal Infirmary; an Ex-President, Section of Psychiatry, British Medical Association; an Ex-President, Medico-Psychological Association of Great Britain and Ireland.

I was formerly Co-Editor of the 'Journal of Mental Science.'

I was Medical Superintendent of the Joint Counties Asylum, Carmarthen, from 1894 *to* 1906.

I was Assistant Medical Officer and Pathologist at the West Riding Asylums, Sheffield and Wakefield, from 1889 *to May*, 1894.

I was Resident Clinical Assistant at Bethlem Royal Hospital, London, for one year.

Altogether I have had some thirty-six years' experience of mental disorders—a life study, in fact.

My evidence is concerned with the second reference to the Royal Commission—*The Lack of Facilities for Early Treatment of Mental and Allied Disorders in England and Wales, and for Scientific Investigation in respect of Causation, Prevention and Treatment.*

This has been insisted on by informed medical opinion for thirty years to my own knowledge. The Lunacy Acts of England and Wales mainly concern themselves with the segregation and care of the "lunatic," the protection of him, of his property, and of the public—wholly legal conceptions. Custodial and fiduciary conceptions dominate these Acts, so that a perusal of them leaves

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one with the impression that merely an alien is being dealt with, and not a sick man. Had the conception of a "patient" rather than a "lunatic" been kept more in view, it is difficult to believe otherwise than that provision for full facilities for the best available treatment, under the least hampering conditions, would have been made. Long before 1890 (the date of the main Act) provision on these lines was recognized as proper for the sick in general. It has been necessary to wait until 1923 to see authoritative recognition given to the need for extending to the insane as a whole the privilege of treatment without subjection to the legal formalities imposed by the Lunacy Acts. The Mental Treatment Bill of 1923 constituted this recognition, and its introduction implied the need for fresh legislation, so that better provision for therapeutic facilities might be made.

Cases of mental disorder, in the earliest phases, amongst the rate-aided classes in England and Wales, at present receive little or no treatment. In so far as they are dealt with at all, it is in common with a mass of incurable disease in asylums (mental hospitals) under the Lunacy Laws, with but little opportunity for classification and individual attention. This means that a volume of early and curable disease has been diverted from the provision made for dealing with disease as a whole, and provided for by segregation in institutions which have no connection with general hospitals, or the centres of medical thought, with which the staffs of those hospitals have the flimsiest association. The investigation and treatment of these cases have, in consequence, been undertaken by a limited number of medical men, who have but little opportunity of keeping in touch with their *confrères* in other branches of the profession (they are segregated, like the patients), and who are not, and cannot be, equipped to deal with the various branches of medicine, all or any of which may be required by these patients. They are assisted by nurses with specialized training only, without general hospital training, with the exception of a few of the officers, such as the matron, and her deputy.

The result has been that insanity has come to be looked upon as a thing apart—as, one may say, a pathological curiosity by the medical profession at large.

Practical arrangements for treating mental disorders in their incipient stages, and for their scientific investigation, are in this country thirty years behind in comparison with leading Continental countries, though the making of such has been urged by the Medico-Psychological Association, or individual members thereof, for a great many years (since about 1889 by individuals, and since about 1911 by the Association).

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At the last (Seventeenth) International Congress of Medicine which took place, and which was held in London in 1913, I acted as one of the secretaries in the Section of Psychiatry. With a view to promoting the establishment of clinics in this country, the opportunity was taken to invite Prof. Sommer, Director of the Clinic in Neurology and Psychiatry at Giessen University, to deliver an address on the subject of these clinics. Nowhere is this system better developed than in connection with the German universities. Amongst other matters, Prof. Sommer informed us that through the working of the Giessen (Hessen) Clinic, the need for providing further asylum accommodation in the Province had been deferred for a large number of years—I do not now recollect the precise figure.

An extensive and regular acquaintance over practically the whole of my service with German, Italian and French medical literature has shown me that by far the most important research work in psychiatry has issued from the neuro-psychiatric clinics associated with the general hospitals and medical schools at university centres.

The Need for Linking up Psychiatry with General Medicine, and the Method of doing so.

It is essential that early cases of mental and allied disorders be brought within the medical fold, that the same medical advantages as are open to patients in general be available for them; that, in short, provision be made for their treatment in connection with general hospitals, as has long been recognized and practised on the Continent. As on the Continent and in the United States, we should have a department or clinic in neurology and psychiatry (in- and out-patients) as one of the departments of the general hospital. The principal clinic would naturally be that at the hospital with which is associated a medical school, and that constellation of medical talent which the activities of such a school creates, and the director would be on the teaching staff of the school. But each large town with a hospital would have such a clinic, and small towns and outlying areas should have, with their comparatively simple hospital provision, arrangements on the same scale for a few neuro-psychiatric cases.

In an article contributed to the *Lancet* of September 11, 1920, entitled "Hospital Treatment of the Psychoses and Psychoneuroses," I set out how these maladies could be brought into the comprehensive scheme for the hospital treatment of disease in general, which was described in the *Interim Report of the Consultative Council on Medical and Allied Services* (which body was

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under the chairmanship of Lord Dawson). In this report mental disease was merely dealt with, and, in my opinion, quite inadequately, under "Supplementary Services." I set out how full provision could be made for this form of disease under the main scheme.

In this way disorders of health manifesting themselves chiefly, or most dramatically, as disorders of conduct (insanity) would be brought into line, in their early phases, with disorders of health in general, and receive all the benefits of the services of general physicians, surgeons and specialists in all branches of medicine. The chief neuro-psychiatric clinic at the medical school centre would also be utilized for research work (research flowing in broad streams, and not sparsely trickling, as now, from some 12–13 *per cent.* of the rate-supported mental hospitals, and commonly the same ones year by year—*vide* annual reports of the Board of Control), for the tuition of students and post-graduate tuition, for the instruction of nurses; and classes of instruction would be held for students of eugenics, for social service and after-care workers, for jurists (forensic psychiatry), etc. There would be lectures on training and education of children, including defective children, on appropriate occupation of persons with tainted inheritance, etc., and also an ambulatory service of lectures and demonstrations for outlying districts. The services of the clinic would be available for courts of justice in respect of the defective and delinquent classes.

The affiliation of psychiatry with general medicine (through hospital staffs and general practitioners), prevention, cure or alleviation of disease in the early phase, lessening of chronicity of disease (which, of course, leads to the filling of asylums), tuition, research—these are the main aims of the clinics.

The practical teaching of psychiatry to students in England and Wales as at present conducted—and I write as one engaged in such teaching—is absurdly inadequate—nearly as much so as it was over thirty years ago, when I was a student. They can (with the exception of Bethlem Royal Hospital, and now the Maudsley Hospital) only go to the "asylum," where cases such as they will be required to deal with in practice are very rarely to be seen. Compare with this the teaching of students at the University of Utrecht, for example (probably the best neuro-psychiatric clinic in existence is at Utrecht).(1) The same lack of teaching facilities

(1) "The Organization of Medical Education in Psychiatry and Neurology at the Dutch Universities, with Special Reference to the Neuro-Psychiatric Clinic at Utrecht University," an address, by invitation of the President, to the Medico-Psychological Association of Great Britain and Ireland on November 22, 1923, by Dr. C. Winkler, Professor of Psychiatry and Neurology, Utrecht (*Journ. Ment. Sci.*, April, 1924).

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results in the appointment of junior medical officers to "asylums," who know very little of mental disorders. This absence of tuition is, of course, very detrimental to our people. As regards nurses, it will be seen that the above plan allows for a free interchange between the various hospital clinics, so that the nurse can receive general and psychiatrical training—a great gain to the public.

No Progress, but merely Marking Time.

Apart from the recently opened Maudsley Hospital, we in England and Wales have for long been merely marking time in psychiatry, and no progress is to be expected until general medicine takes cognizance of this branch, which will be feasible when provision on the above lines is made.

In the *British Medical Journal* of September 27, 1924, there appeared an article entitled "Early Mental Disease Treated in a General Hospital: An Analysis of 500 Cases," by Dr. John D. Comrie, Senior Assistant Physician to the Royal Infirmary, Edinburgh. These patients were treated in wards of the Infirmary which are reserved for early mental cases and cases of incidental delirium. Such an arrangement is not the equivalent of a separate neuro-psychiatric department *ad hoc*; it is by no means the ideal. But the results obtained afford a good illustration of the advantage of treating early mental cases on general hospital lines and at a general hospital.

To associate these clinics with existing mental hospitals would, I strongly hold, help to perpetuate the present unfortunate segregation of early and recent mental disorder from disease as a whole, and thereby interfere with the provision of the best available medical attention. This step would infringe the cardinal principle, that the cases to be dealt with and the research to be conducted should be in the hands of the staff of the general hospital, upon which staff would be the director of the clinic as an expert.

Only in this way will the clinic be regarded as an integral part of the hospital, and secure the interest of its staff, and the full confidence of patients.

First Step in Linking Up at Cardiff.

Nearly five years ago I started an out-patient clinic at the Cardiff Royal Infirmary with the approval of my committee and the General Hospital authorities, mainly in the hope and belief that it would serve as an object-lesson in the need for an indoor clinic (to receive not merely "borderland," but certifiable cases, which, however, need not and should not be certified for

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reception therein), and so help to prepare the way for the setting-up of such when the hoped-for Mental Treatment Bill should become law. This out-patient clinic deals not only with fresh cases referred to it by medical men, or from other out-patient departments, and from the wards of the Infirmary, but also with patients out on trial from the local mental hospital. Anyone requiring evidence of the need of full facilities for the treatment of early cases of mental disorder and borderland cases could not do better than attend such an out-patient department on a few occasions. Scarcely a week passes but I feel the need for an indoor department.(1) I should say some 65 *per cent.* of the new cases require indoor care, but not that now available under the Lunacy Laws. I am constantly explaining to the relatives of the patient, or the latter, that, as matters now stand, there can be no provision in connection with the Cardiff Infirmary for such cases. They would gladly avail themselves of this form of treatment, but are not willing to go to the mental hospital.

An indoor clinic cannot be created merely by the conversion of ordinary hospital wards, or of a taken-over building, but must be erected for the purpose.

Cases which should have been Dealt With in a Better Way.

Large numbers of cases are annually received into the Cardiff City Mental Hospital which are obviously cases for a psychiatric clinic in association with a general hospital, unconnected with the Lunacy Laws, and for which judicial orders and medical certificates —as called for by these Laws—and handling by the machinery of the Poor Law are wholly unnecessary and undesirable. Under present conditions there is no alternative.

In 1922, out of an average of direct admissions (based on that and the preceding year—being post-War Office occupation years) of 140, I find that 22 left recovered and relieved within three months, 19 within the next three months—or 41 (29 *per cent.*) within six months ; like figures for 1923, based on direct admissions, numbering 192, were, respectively, 53, 25 and 78 (40 *per cent.*)

If two pre-War Office occupation years be taken (1912 and 1913), for 1912, out of 170 direct admissions, 51 left recovered and relieved within three months, 26 within the next three months—or 77 (45 *per cent.*) within six months ; like figures for 1913, based upon 170 direct admissions, were, respectively, 28, 23 and 51 (30 *per cent.*).

In addition to the above, between the opening of the hospital in June, 1908, and 1914 (both dates inclusive), and from January,

(1) In support of this view, *vide* The First Annual Report of the Medical Superintendent of the Maudsley Hospital.

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1921, to the present time—intervening years being excluded as the hospital was in War Office occupation—39 patients were found "not insane now" within a brief period of observation after admission.

My contention is that cases which could recover in this short period of time need not (and would not) have been dealt with under the Lunacy Laws (orders and certificates, and Poor Law transit—these undoubtedly constitute a painful ordeal for the relatives, and a painful memory for them and the patient on recovery; in some instances a grave social disability for the latter), had the psychiatric clinic system been available. Their treatment under the latter system would have been far more rational, enlightened and efficient.

The Mental Treatment Bill, 1923, contained provisions which allowed for the development of early treatment of mental disorders in association with general hospitals, on the above lines. Local authorities (visiting committees of mental hospitals) were therein authorized to make agreements with the managers of hospitals which the Board of Control had approved as institutions for receiving cases of mental disorder.

The medical work at a psychiatric clinic will be on a higher grade than what is possible at a mental hospital, however well found, because—

(*a*) The staff in proportion to patients is more numerous and can give more time to them, allowing for the consideration that mental hospitals contain mostly chronic cases—these, nevertheless, absorb much time in respect of records and sickness.

(*b*) The staff at a clinic is assisted by a number of voluntary qualified medical men, who are there for tuition and research. These will not be found at mental hospitals, as the latter contain mostly incurables and end-results of disease, and are mainly remote from medical centres.

(*c*) The clinic staff will command the services of the best qualified men, and this for obvious reasons.

It is therefore evident that these clinics will be greatly to the benefit of the patients.

I do not deal with the mode of reception and discharge of cases with and without volition into psychiatric clinics, as I adhere to the procedures set out in the above-mentioned Bill, as modified and advocated by the Medico-Psychological Association.

The treatment of cases of early mental disease in association with cases of disease in general will bring about more rational views, alike amongst members of the medical profession and the public, as to the nature of so-called "insanity."

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APPENDIX III.

MEMORANDUM ON

THE CENTRAL AUTHORITY—RECOMMENDATIONS 16–20 (p. 12).

THE LOCAL AUTHORITY—RECOMMENDATIONS 21–23 (p. 13).

By W. F. Menzies, B.Sc., M.D.Edin., F.R.C.P.Lond.,
Medical Superintendent, Stafford County Mental Hospital, Cheddleton, near Leek.

PRELIMINARY.

Public agitations for the improvement of the conditions of persons confined in institutions for the mentally disordered tend to arise, roughly speaking, at intervals of about forty years, and it is desirable that suggestions towards this end should justify themselves for at least a generation. The Medico-Psychological Association has always held that it has been to the detriment of the mentally ill that so much stress has been laid upon the protection of the person against segregation, and so little upon the need for medical treatment of the sick man. They are satisfied that the principle of *habeas corpus*, however desirable on most grounds, does tend to interfere with treatment designed to promote the patient's recovery, and in making their recommendations to this Commission they have looked around for means of broadening supervision, of taking the educated public more into the confidence of those who have to supervise mental institutions, of bringing the needs of the mentally ill more into line with the requirements of modern scientific medicine, and at the same time of avoiding any undue increase of the public financial burdens in these respects.

THE CENTRAL AUTHORITY.

Those who are acquainted with the evidence given before Lord Shaftesbury's Commission, whose report eventuated in the Lunacy Acts of 1845, will acknowledge that the appointment of a Board of Commissioners in Lunacy (enjoying emoluments which were at that time liberal and thus securing the best type of person), was nothing short of a stroke of genius. We consider that the long procession of far-sighted and talented men who have served as

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Commissioners in Lunacy has been, more than any other, the potent instrument which has elevated the treatment of the mentally ill to its present highly humane level, and has made it a model for all nations to follow. The Board may have, until recent years, fallen short in the pursuit of scientific medicine, but this has been due primarily to financial restrictions and the public call for economy; its administrative policy has not been, in our opinion, open to serious criticism, and we are speaking in the names of those who for over seventy years have been brought most intimately into working connection with the Lunacy Commissioners, since 1914 the Board of Control. We believe that no new body could do better, and might, if financial considerations limited the type of person to be appointed, do a great deal worse. It is alleged that certain bodies interested in some small institutions run on eleemosynary lines object to inspection or control by any central authority. But I have not heard it said that such persons object to systematic inspection of the large county and borough mental hospitals, which, being more under direct public control, one would imagine to require it less. Again, others desire a new body under the direct control of the Ministry of Health, a department analogous with, or even subsidiary to, a public health department. But would any such body, by whatsoever designation called, be looked upon by the public ten years hence as differing except in name, from the present Board of Control? As soon as such new body began to show that it was appointed to interpret public opinion at large, and not merely to prevent the certification of a small percentage of antisocial persons it would call down upon its head from dissatisfied cranks much the same criticism as does the present Board of Control. It is important that the central authority, while being answerable to Parliament through a Minister of the Crown, should yet not become a mere department, it should be independent of politics and have a permanent policy. We feel strongly that the Board should be in personal touch with the Minister of Health, but not a department of the Ministry. The problems involved require a life study and no medical officer of health could devote the necessary time to learning the technical detail necessary for the framing and interpretation of the regulations upon which the daily life of our large mental institutions depends. In many of these matters one is not dealing with the rigid details of discipline, but with the intimate thoughts and desires of human souls, who vary in almost every respect from one another and from the normal. The interpretation of the wording of a rule or custom may require modification in a hundred ways to meet the temperaments of various patients or else unnecessary hardship may arise. A simple letter may

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require many different answers according to the mental or intellectual state of the writer, yet each alternative must convey an attitude of friendship, interest and personal consideration. These are only given as instances of the need for long experience and technical knowledge on the part of members of the Board. The Medico-Psychological Association is definitely of opinion that psychiatry should be allied to public health, but that the supervision of institutions should continue to be exercised by an experienced autonomous body to which medical officers of all various types of mental institutions should be responsible. Further, the central office of the Board of Control can be carried on efficiently only if a material proportion of its members are past medical superintendents of mental institutions, who have previously devoted many years to a daily consideration of the problems which will have to confront them on the Board. But that position cannot be achieved at present, matters are at a deadlock. No experienced medical superintendent can afford to submit to a reduction of £300 to £400 in his annual income, because he is usually a man with a growing family and has to meet large and increasing expenditure on educational fees. The salary of the medical members in ordinary should be at least £2,000 per annum on present values, and we especially stress the necessity for provision being made for carrying towards pension their years of service under a local authority.

A large part of the time of members of the Board is spent on circuit. If some of this could be saved the work of the central office could probably be accomplished by four medical members. Then the question arises whether four legal members are necessary. If one were always on duty surely all legal questions would receive ample attention. We must therefore provide in some other manner for inspection and visiting of mental institutions of all kinds and of cases in single care. Clearly if this is to be adequately done by members on circuit from the central office a larger number would be required and the expense would be unduly great. There are, from the certified patient's point of view, two chief objects in visits: (*a*) To satisfy him that his detention is, if unpleasant, at least not illegal; (*b*) to see that his treatment is such as will conduce to comfort, and if possible to cure. All such statutory visits should therefore be paid by a medical and a legal visitor, who would have power to report only, not to enforce orders. These visitors need not be full time persons, but could be inspectors appointed by the Minister of Health from among the local legal and medical practitioners in each area, and paid by fee. Probably they ought to visit at least twice a year, and should report on each visit to the Board. There can be no doubt that such inspectors would be

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welcomed by patients, and the visits would tend to alleviate the suspicions of a section of the public. They could be approached at any time by letter, could visit and investigate individual cases quite informally, and generally would be the local friends to whom dissatisfied patients could appeal without the formality of writing to the central office. They could arrange small difficulties before they became grievances, they would be of great help to the Board and responsible minister in more important appeals. Their value would depend on absolute dissociation from appointment or control by the local authority.

We next come to a feature of the work of the central authority which has not hitherto received adequate attention, *viz.*, the periodical visiting of institutions and single cases by medical consultants of high eminence in the profession, not necessarily, or even of choice, members of the psychiatric specialty. These should be able to give advice and consultation to committees and their medical officers on the latest scientific trends of general medicine and surgery, in order that institutional medicine may not fall behind. For it must be remembered that most mental hospitals are far removed from towns, that their medical officers are overwhelmed with administrative details, are always giving out intellectual ideas and receiving none in exchange, are far from medical societies and libraries and find great difficulties in obtaining the time and opportunity to keep abreast of modern medicine. For the profession of psychiatry trenches upon many subjects—physiology, comparative biology, palæontological geology, biological chemistry and parasitology, archeology, ethnology, neurology and psychology. No man can master all these subjects, and we always welcome new light which leaders of medical thought are able to throw upon our particular problems. Personally I find that unless I can devote two hours each evening to medical literature I at once begin to fall behind.

It is argued that such consultants can be called in locally and for particular cases, but this would not adequately fulfil the purpose. These may know little about mental institutions or mental disorders. In point of fact they call us in consultation to their own cases outside, and inevitably, if called to consider allied problems of mental disease they would say "If you don't know all about this case who does?" There should, therefore, in my opinion be included on the central Board certain eminent medical men, who should visit each institution at intervals, say once in two years, in order to inquire into the standard of medical treatment. These consultant commissioners need probably not be full time men, lest they too begin to fall behind in professional

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knowledge. Far better that they be present or past teachers of the great schools. They might be paid by fee.

These propositions as to the paid members of the central authority may be thus summarized :

(*a*) Paid Commissioners in ordinary to include at least four medical and two legal members, the former of whom shall have been medical officers of mental hospitals. One should have special experience in Mental Deficiency, another experience in Private Patients mainly. These commissioners may visit institutions once in two years ; the legal members need not go on circuit. The medical members to be paid at least £2,000 per annum and to count towards pension the years served under a local authority, which would contribute proportionately towards pension.

(*b*) Local inspectors to be appointed by the Ministry of Health and be subject to the direction of the Board, one medical and one legal inspector together to visit each patient twice a year and oftener if required in individual cases.

(*c*) Associate medical commissioners to visit institutions once in two years to advise medical officers as to treatment.

Always provided that none of the above periodic visits need be duplicated. Also provided that inspectors are not to be promoted to be commissioners when vacancies arise.

The Medico-Psychological Association does not consider that the present name " Board of Control " is the best which could be chosen. There are, and have been, other boards of control, and they all suggest legal direction, not medical treatment. We consider that " Board of Mental Health " would fully describe the necessary field of intention without discriminating between control and treatment, would fall in with the designation of the minister concerned and would suggest correlation with the local committee both of public health and of mental health as about to be described.

THE LOCAL AUTHORITY.

At present the management of rate-aided mental institutions by the local authority in most counties is divided between the mental hospitals committee and the mental deficiency committee. Amalgamation has taken place in a few cases, but should be the universal rule. Consequent difficulties arise in the free interchange between the institutions appropriate to each class, and even in such fundamental points as basis of contribution towards superannuation of officials, distinctions exist which make it almost impossible to afford that free interchange of patients which modern medical treatment

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requires, especially in the great class of borderline cases who are congenitally affected and suffer at times from superadded psychoses. The boards of guardians have charge of both the mentally ill and the mentally deficient, the education committee of the local authority has control of certain classes of mental defectives. If the recommendations as to clinics set forth by the Medico-Psychological Association become effective the local authorities will be responsible for the maintenance of these, which will bring them into contact with the managers of voluntary hospitals. There are certain other bodies which are interested in the care of the mentally ll and defective, for example, Nursing Associations in counties and county boroughs, health visiting committees, infant welfare centres, the After-care Association and voluntary welfare committees generally, ex-service men's associations, the Ministry of Pensions and Orthopædic Associations.

A clear distinction must be made between committees directly responsible to the ratepayers, such as local authorities and boards of guardians on the one hand, and voluntary or merely rate-aided bodies on the other. There is a precedent in Committees under the Education Acts which secures to the ratepayers control over their institutions. The local authority would, by its amalgamated Mental Hospitals Committee and Mental Deficiency Committee, have a majority of members on the new committee, but one, two or three from all other bodies concerned, including boards of guardians as long as these exist, would be co-opted. The management of all mental cases, whether of illness or deficiency, would be removed from the guardians, who would, however, have representation on the new committee. We suggest that the new committee should be called the Committee of Mental Health. In areas where mental hospital boards exist arrangements would be rather more complicated, but there need be no insuperable difficulties. It is suggested that the mental health committee should be responsible for the entire maintenance of necessitous patients, as well as the fabric and furnishing of all buildings required for their treatment. They would raise the money in the usual way by requisition upon the various authorities, and they would pay rental as arranged to boards of guardians, voluntary hospital authorities and others for the accommodation required. They would manage the various classes of institutions through sub-committees. They would probably require to appoint a Medical Officer of Mental Health who would be responsible to the Committee for the entire organisation. In small local authorities the medical superintendent of the mental hospital might act, but under very large boards, *e.g.* Lancashire, it might be necessary to appoint as many as three

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full-time officers. These officers must be of long experience and administrative ability, and should hold rank with, but independent of, the County Medical Officer of Health. In the first instance they might be chosen from the ranks of medical officers of mental or mental deficiency institutions. It might be necessary for the local joint committee of mental health to appoint other officers, but as a rule these would be doing much of the work at present performed by relieving officers and inspectors of voluntary associations, and it might be well in the first instance to make arrangements with these bodies for part-time services.

Our objects in recommending the arrangements described above are not merely for the sake of economy by the avoidance of duplication; they go much further. We believe that they will secure for the patient a much more varied choice of treatment, especially uncertified early treatment, and will effect that co-operation of outside medical skill in respect of bodily disorders present in the mentally ill which the present arrangement of water-tight compartments renders difficult and expensive; that they will, by bringing the treatment of mental illness into line with general medicine, help to break down the suspicion and terror produced in many uneducated minds by the threat of a psychosis, and so will conduce towards making voluntary treatment more popular; and that they will assist in educating the public concerning mental institutions by widening the circle of those who may be called upon to take an interest in their management, and so diminish the repeated accusations of abuses which, except in altogether exceptional cases, exist only in the phantasies of abnormal minds.

When the sum of 4*s.* per head per week was inserted in the Lunacy Act as the amount to be paid by the Government to Boards of Guardians for each patient sent to an asylum, it would appear that the intention was to pay about 50 *per cent.* of the cost of maintenance. As the average weekly cost is now about 26*s.* per week the amount of the central grant becomes ridiculously inadequate. The money under our suggested scheme would be paid to the local authority, who are, in fact, already responsible for structural upkeep, and we consider that the 50 *per cent.* share should be restored. But it should not be paid indiscriminately. Some local authorities recognize their duties to the mentally ill, and encourage every reasonable means to promote recovery. To them this financial relief would be paid in full. Other authorities place economy before efficiency; these would get nothing. We would suggest the analogy of the Education Acts or road grants, payments by results, or by the comparative importance of the heads of expenditure to be incurred. There is no other body than the Board

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of Mental Health who would know whether or not the money was being properly spent and whether an adequate return in recoveries or increased comforts to patients might be expected. We would recommend that payments should be made only on the certificate of the Board. They know that often expenditure upon scientific research or special teaching or a clinic might be a better investment than mere extra amounts spent upon furnishing and building. They alone could take all the facts of the case into consideration and appraise to each its proper value.

There is considerable dubiety among mental hospital committees as to what expenditure is at present legal, and certain desirable objects cannot be attained unless the judicature specifically rules them to be legal. We refer to scientific research, more particularly to grants towards this object made to outside authorities, such as combined boards who may conduct a central research laboratory. There are also matters like payment to outside teachers and examiners for instruction in special courses of mental medicine and nursing, diploma courses within and without the local authority's area, and payments to mental hospital patients for work done in the institution. All these items are probably at present legal, or at least they have not been surcharged. But in the absence of judicial ruling some local authorities will not take the risk. Another very necessary expenditure is at present probably illegal, this is any payment by a mental hospital committee of grants in aid of after-care schemes in the case of patients who have been finally discharged. At present the financial liability of a committee ceases when the name of a patient is removed from their books, although it is, in our opinion, a necessary link in the scale of treatment that it should be able to recognize officially, by monetary grants or otherwise, the work which has been carried on under considerable difficulties since 1886 by the Mental After-Care Association. Large numbers of men and women, many of them poor, some friendless, are discharged from institutions every year, yet who are capable of earning their own living with a modicum of assistance, such as temporary boarding out in homes, convalescent or otherwise, a short period of change of air or scene, provision of suitable employment, money grants towards seeking work or obtaining clothing or tools. This work is at present legally performed to some extent by boards of guardians, but only at the cost of the stigma of pauperism.

We would go so far as to recommend that, subject to the permission of the Board of Mental Health, expenditure upon the above subjects should be not only permissive but statutory.

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APPENDIX IV.

PRÉCIS OF EVIDENCE.

ON

PSYCHIATRY, LEGAL AND ADMINISTRATIVE, IN SOME EUROPEAN COUNTRIES AND IN AMERICA.

By Lt.-Col. J. R. LORD, *C.B.E.*, M.B.Edin.,
Co-Editor of the *Journal of Mental Science.*

SOME EUROPEAN STATES.

FACILITIES FOR EARLY TREATMENT OF OCCURRING MENTAL DISORDER.

France.—There is no provision at present under the French law for a mental patient, on his own request and apart from his relatives and friends, to receive treatment in a mental hospital, but in the new Lunacy Bill now before the French Parliament this is being allowed for and will be known as "spontaneous internment." A mental patient desiring treatment or not unwilling to be treated can only be received in a mental institution by the action of his relatives or friends, who effect what is known as "voluntary internment" (*un placement volontaire*). This method of placing mental patients under care is applicable whether the patient is willing or not, and will be described later. Many uncertified cases are treated in special departments attached to the general hospitals.

Dr. Henri Colin (*vide Journ. Ment. Sci.*, October, 1921, p. 461) says:

> "The treatment of the psychopathies is at the present time imperfect. It only concerns itself with conditions of confirmed insanity, which has reached a stage when the chances of cure are restricted. The irksome formalities, and in a certain measure vexations, of certification keep the milder cases away. The asylum in its present form is expedient only for the dangerous and incurable insane."

Referring to treatment of voluntary or uncertified patients he says:

> "In France the law of 1838 is silent on this point. It did not foresee clinics for uncertified patients, any more than it foresaw family colonies. Now family colonies exist in France, and prosper. It will be the same with uncertified clinics; and already at Fleury-les-Aubrays, near Orléans, services exist where the patients can enter voluntarily. Thus nothing prevents the generalization of the system."

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The following reply was sent by the Société Clinique de Médicine Mentale to a letter from the Minister of Health on the subject of the revision of the Lunacy Law of 1838:

"The expression 'mental affection,' the meaning of which is wider and less precise than that of the expression 'mental alienation,' denotes mental alienation, and also other morbid states characterized by mental troubles. Those persons suffering from mental affections ought to be regarded as alienated—

"(1) Who compromise public order.

"(2) Who are, or may become, dangerous to themselves or others.

"(3) Who, incapable of properly managing themselves, or of supplying their needs, do not receive from their immediate *entourage* or from public assistance the supervision and care that their condition renders absolutely necessary.

"Thus, only the alienated, to the exclusion of other patients afflicted with mental disorder, ought to be the object of legal measures restrictive of individual liberty.

"The substitution of the expression mental affection for the expression mental alienation might have the consequence of improperly extending these measures. There is thus cause for avoiding such a substitution.

"Now patients suffering from mental affections in general, and not merely the alienated, deserve to be treated, and the law could extend the benefit of personal or voluntary placing to all mental affections.

"As far as this refers to the poorer classes, and if one excludes some hospital services of the large towns, the insane asylums are actually the only establishments for the treatment of mental affections in general, and there is nothing to hinder those persons suffering from mental affections, but not alienated, from being treated in the asylum, if they desire it, if they enter freely, if their stay in the establishment is medically justified, and if they leave freely, though not cured, upon the single condition that they are not dangerous. The opposition of the responsible physician to the discharge of a voluntary patient should always become the object of an immediate and careful inquiry analogous to that occurring on admission."

In France the Lunacy Law of 1838 has remained unchanged except for the Emergency Law of March 21, 1919, dealing with mentally afflicted soldiers. A projected revision of the Lunacy Law was interrupted by the outbreak of war. In France, as in this country, there is a volume of opinion, both medical and otherwise, in favour of voluntary treatment of early cases of mental disorder uncertified, whether certifiable or not, in the wards of infirmaries (dispensaries), general hospitals, asylums, at special clinics (with laboratories), and by attendance at the out-patient departments of dispensaries and hospitals.

In France, before a person can be sequestered as insane his insanity has to be proved, but Art. 510 of the Code Napoleon permits the "family council" to take the necessary action.

The Law of 1838, like our existing Lunacy Laws, contemplates the treatment of all psychopathic cases under a form of certification. It has failed, however, in France as far as early treatment is concerned, and it seems likely that this will be effectively provided for in the revised law now before Parliament.

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Italy.—Voluntary admissions to psychiatric hospitals and provincial asylums are permitted. Such admissions are immediately notified by the Director of the hospital to the Attorney of the King (*Il Procuratore del Re*).

Art. 53 of the Regulations in the Law relating to Asylums and the Insane reads:

"When individuals of full age, being aware of their own condition of partial mental aberration, request to be received in asylums, the manager, in case of absolute urgency, and on his own responsibility, may receive them provisionally under observation, giving advice thereof within twenty-four hours to the Attorney of the King, subject to reporting to him, by order of the Tribunal, as in ordinary cases, and to the Police Authorities. The usual procedure follows.

Professor Leonardo Bianchi, a member of the Italian Senate, said on June 9, 1922:

"Our law has been inspired by the desire for the public safety, and not from the point of view of the hospitals. In obedience to our law, only those persons are admitted who are judged to be dangerous to themselves and to others."

"There are a large number of patients whose malady springs up acutely, for instance, those who are ill from intoxication or infection, typhus, malaria, or acute alcoholism, etc., which, if they were looked after at the proper time, might be cured very rapidly. Now as for the admission of these into the lunatic asylum, it is necessary to carry through the procedure either with the Police Authorities or with the Tribunal; it is quite natural that many families refuse to send their patients to asylums for the reason that the Police Authorities and the Tribunal imprint an indelible mark on the honour of the family (even if this be only prejudice), and consequently, these patients remain in their own houses, either not cared for or badly cared for.

"For this reason the malady often passes into a chronic state, and it is only then that the respective patients are admitted in the lunatic asylum, but it is perhaps too late for a rational treatment; for this reason it is necessary to make different arrangements for the admittance of these patients."

Spain.—Voluntary admissions take place, but the law regarding certification is afterwards carried out on the initiative of the patient.

Holland.—Patients, on application to the Tribunal can be received voluntarily at the asylums. They can be received without authorization at the official psychiatrical clinics.

Psychiatric clinics may receive certified cases without restrictions, but general hospitals are only allowed to accommodate two certified cases.

Germany.—In Germany the care of mental patients is not regulated by a lunacy law common to the Empire. Each Federal State is governed in this respect by its own laws and by its Government decrees. There is no special lunacy law in Prussia—only Government decrees (a matter of ministerial administration).

The Baden Lunacy Law of June 25, 1910, is said to be well

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thought out and the most enlightened. Another recent lunacy law in Germany is that of Saxony dated 1912.

There appears to be ample provision for voluntary admission to all mental institutions either by the person afflicted or on his behalf by his friends. As regards asylums, the applicant for admission must produce papers of identification and guarantee payment of the cost of maintenance.

Austria.—Voluntary admissions are permitted both to psychiatric clinics and asylums. The patient writes a declaration in the presence of two witnesses and the medical officer of the institution that he agrees to stay.

CERTIFICATION AND ADMISSION TO MENTAL INSTITUTIONS.

France.—In accordance with the Law of 1838, there are two methods of placing the mentally afflicted under care in public and private asylums:

(*a*) Voluntary internment (not ordered by the State). To effect this it is necessary to produce the following documents with the patient:

> (1) The demand for admission containing the name, occupation, age and addresses both of the patient and the person effecting the internment.
>
> (2) A medical certificate (or several) giving mental state of patient and the reasons for internment. This certificate must not be signed by a medical officer attached to the receiving asylum, nor by one who is a relative or connection of the heads of the establishment or of the person effecting the internment.

(*b*) Official internment is by order of the Prefect of the Department (in Paris, the Prefect of Police), and applies to any person whose mental state compromises public order or the safety of individuals. In urgent cases mayors of communes can act and refer the same to the Prefect within 24 hours.

Judicial authority only intervenes when an insane person has broken the law.

All admissions are notified to the Prefect within 24 hours of admission, with a report from the medical officer of the ayslum.

Italy.—The internment of an insane person in an asylum takes place as a rule in two stages: (1) Provisional; (2) confirmatory.

A relative of the person to be interned, or the guardian, acting guardian or trustee, obtains a detailed medical certificate from the doctor in charge of the case (who must not be a relative, even in

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the fourth degree, of the patient or of the manager or the owner of the asylum, or nursing home selected, nor may he belong to such asylum or nursing home). He then proceeds to the Magistrate, or, in communes which have not a district court, to the Mayor, with four witnesses, who are not members of the family of the patient and are acquainted with the patient, if possible residing in the neighbourhood of the latter, who have the legal position and are persons of good repute and worthy of confidence. The latter must confirm the statements written by the doctor, and the circumstances which lead to conclude the state of mental aberration of the individual. The "act of notoriety" arises in this way.

Then, on the basis of the medical certificate and the "act of notoriety," the Magistrate issues a "decree of provisional retention" in an asylum, which authorizes the Manager to receive the patient.

The Manager immediately advises the Attorney of the King of the internment effected, and within 15 days (if the diagnosis cannot be effected within this period, a further 15 days may be asked for and obtained, but not a day longer) it must be declared to the Attorney of the King that the internment of the patient in the asylum is considered absolutely necessary (dangerous to himself or others). Then the Tribunal issues and sends to the Manager a "decree of definite retention."

Spain.—The internment is in two stages: (1) Provisional; (2) confirmatory.

Two medical certificates are required for the former and the provisional order is made by the Mayor. Other formalities prior to admission are the examination of the patient by the Medical Officer of Health (Subdelegado). The Subdelegado seldom visits the patient, but always receives a fee for his signature and seal. Municipal practices vary, but the Mayor, before he signs the order, usually orders further investigations by two municipal physicians, whose reports are confidential.

After three months the order is confirmed if necessary by the Judicial Authorities after inquiry and reports from the Medical Director of the asylum and the Medical Adviser to the Court of Justice. The Judicial Authority means a judge sitting as in a civil suit. The application is first heard by a local magistrate, and notified in the Official Journal of the Province 30 days beforehand.

Holland.—The internment is in two stages: (1) Provisional; (2) confirmatory.

The internment in an asylum is effected by the members of the family and an order from a cantonal magistrate.

One medical certificate must be submitted giving the mental

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state of the patient and the need for internment. The order is effective for six weeks.

At the end of this time the Tribunal can extend the order to one year, which is renewable annually.

Germany.—(*a*) Public clinics: The psychiatric and neurological clinics admit quite freely the mentally afflicted or people suspected of such, and no medical certificate or judicial order is required. As a rule a medical report accompanies the case. They also admit without formalities persons ordered there for observation by the Civil and Criminal Courts and the Police Authorities for several reasons.

(*b*) Public asylums, like the clinics, admit without formalities police and court cases.

In the case of a patient for whom internment is necessary the following documents must be produced: (*a*) A police certificate as to the patient's origin, family and circumstances; (*b*) a guarantee or statement as to the payment of the cost of maintenance; (*c*) a written declaration of consent by the legal representative, or by the "Competent Authority"; (*d*) one detailed medical certificate. The application as a rule is addressed to the "Provincial Captaincy," which is the head of the Provincial administration. The following persons are entitled to make such applications: (*a*) Poor Law Authorities; (*b*) the nearest relative or the legal representative (guardian or trustee of the patient). These provisions are not absolutely uniform in all states or provinces. There is no judicial authority required.

The following extracts from the Bavarian Codes of Penal and Civil Procedure and Police Penal Codes are interesting as illustrative of German lunacy procedure in certain cases:

Section 81 *of the Code of Penal Procedure.*

For the preparation of an opinion on the mental condition of the accused party, the Court, on the application of an expert, after hearing the defending Counsel, may order that the accused person be conveyed to a public lunatic asylum, and that he be observed there.

A defending Counsel must be appointed for an accused person who has not one.

Immediate objection can be lodged against this decision. (The effect of this is to defer its action.)

The internment in the institute may not exceed the period of six weeks.

Section 656 *of the Code of Civil Procedure.*

With the consent of the applicant, the Court may order that the person interdicted be brought for a period not exceeding six weeks into a curative establishment, if this appears to be desirable, according to medical opinion, in order to ascertain his mental condition, and if this can be carried out without detriment to the condition of health of the person to be interdicted. (Before the decision the persons referred to in Section 646 should be heard as far as practicable.)

Against the decision by which the internment is ordered, the person to be interdicted, the State Prosecutor, and within the term granted to the person to

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be interdicted, the other persons mentioned in Section 646 have the right to lodge an opposition immediately.

Article 80 *of the Bavarian Police Penal Code.*

Anyone who, to the danger of persons or property, or to the danger of public morality, allows idiots or mental patients whose supervision is incumbent on him to go about freely in the streets or in public places, will be punished by a money fine up to 15 thalers (now up to 45 marks).

If such a person has made an attack against persons or property belonging to others, or has acted contrary to public morality, and either no penal proceedings have even been instituted because the accused person is not responsible for his actions, or a recognition of this has caused the penal procedure to be stopped, or if the danger to the community of such a person has been ascertained in some other way, the Police Authorities are entitled, on the basis of an opinion of the district medical authority, to order the internment of such a person in a lunatic asylum or sufficient supervision to be exercised over him in some other way.

Article 81(d) *of the Bavarian Police Penal Code.*

Anyone who allows children, sick persons, defective or idiots or other suchlike helpless persons belonging or entrusted to him to be neglected in regard to protection, supervision, care or medical assistance, will be punished by a money fine up to 30 thalers (now up to 90 marks), or by imprisonment up to four weeks.

In the penal judgment it may be decided that the Police Authorities are empowered to care in some other way for the accommodation of the persons in question at the cost of those whose duty it is to do so. The power to do this, when it is a question of a measure for which an Order of the Chancery Court is required, is dependent on the granting of the said Order.

Austria.—A distinction is made as to whether the person to be dealt with is suspected of mental disorder or is a case of undoubted psychosis.

In the former case the internment is in a clinic (observation station) and not in a public asylum. It is effected on the certificate of the Official Medical Officer (police physician, district physician, etc.). The clinic ascertains the patient's mental state and, if normal, discharges him. If found to be suffering from mental disorder his transfer to the nearest asylum is ordered.

For admission to a public asylum one certificate is necessary as to the mental state of the patient, which must also state that the patient is dangerous as regards himself and his environment. As a rule this certificate is issued by the District Medical Officer except in "urgency cases," when any practitioner can certify, in which case the Director of the asylum must send a report within 24 hours to the Police Commissariat or District Captaincy. Examination by the District Medical Officer follows.

Every case admitted to a public asylum is notified to the Provincial Courts (Civil), following which the patient is examined medico-legally (by one judge, one or two court psychiatrists and one Secretary) to decide whether the internment is admissible. A subsequent examination by the Provincial Court is held to settle any question of guardianship.

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URGENCY CASES (ADDITIONAL NOTES).

France.—The medical certificate can be dispensed with.

Italy.—In cases of urgency (or in order to avoid the slowness of the ordinary procedure with the magistrate), the relative of the insane person to be interned, furnished with the medical certificate, can obtain a decree of provisional retention from the Police Authorities. The subsequent official formalities are the same as in ordinary cases.

Spain.—The Mayor or Magistrate or Governor of the Province may decide on immediate internment, but the ordinary procedure must follow.

Holland.—Can be dealt with by the Mayor of the Municipality instead of the Cantonal Magistrate. The case can be received in any large hospital.

Germany.—Urgent internment can be effected without medical certificate. The Medical Officer of the asylum certifies afterwards.

Austria.—Certificate of any medical practitioner is sufficient to effect internment. The Police Authorities are notified within 24 hours.

SPECIAL PROVISIONS FOR PAYING-PATIENTS.

France.—There are private hospitals which are subject to the same regulations as the public asylums, except that the Prefect immediately orders an examination by a psychiatric inspector. There are also " pensionnats " attached to certain public asylums. Certification does not differ.

Italy.—All private mental institutions are subject to the same laws as the public asylums. Certification does not differ. The same applies to patients treated at home or in nursing homes.

Spain.—The same as Italy in this respect.

Holland.—There is no difference in the law as regards paying and non-paying patients. There are sanatoria in which paying patients place themselves for treatment as nerve patients. If necessary they are certified and sent to the mental division of the institution.

Germany.—There are many private mental institutions, homes, etc., and private mental nursing agencies.

Paying patients in limited numbers can be received in public mental hospitals. There may be several classes of paying patients. In Berlin there is only one class of mental hospital, which includes those who pay and those who do not.

The medical certificate presented on admission must be made out by the District Medical Officer or the Director of a public mental hospital or clinic. If the patient is already under guardianship,

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then if the admission is authorized by the guardian, the certificate of any medical practitioner suffices.

Urgent admissions on the certificate of any medical man are allowed, but the District Medical Officer must then be notified within 24 hours, who examines the patient within 3 days after the receipt of the notice.

Voluntary admission to private institutions is permitted on the production of the following documents:

(*a*) A medical certificate that the patient understands all about the admission and that he is a suitable case for care and treatment.

(*b*) The written declaration of the patient that he wishes to enter the hospital.

Austria.—There are some private sanatoria for mental cases and "paying departments" in the mental hospitals.

The law regarding admission is the same as in the case of public mental hospitals.

DISCHARGE OF PATIENTS.

France:

Recovered.—By the asylum in the case of "voluntary internment."

By the Prefect in the case of "official internment."

By the Attorney of the Republic in the case of minors of a person "interdicted."

Not recovered.—If interned "voluntarily" by the relatives or guardian or other person who has effected the internment unless the Medical Officer deems the patient to be dangerous. Discharge is then suspended and the Prefect informed, who converts the "voluntary internment" into an "official internment."

Italy:

Recovered.—By the psychiatric hospital to his family.

If the family do not remove him, then the President of the Tribunal or the Police Authorities or the Mayor of the Commune at the place of origin of the patient is notified to effect the removal.

Recovered.—By the asylum to his family.

If the family do not remove him, then the Police Authorities effect removal.

Not recovered.—The patient who is improved but not recovered, however, may be discharged "under the legal responsibility of the Manager" (who may secure himself by

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requiring a signature of guarantee on the part of the relative who takes charge of the patient. This signature has, however, only a moral and not a legal value).

Advice of "discharge recovered" is immediately given to the Police Authorities and to the Attorney of the King, who must then obtain from the Tribunal a "decree of definitive discharge," which is, however, usually issued a long time after the patient comes out.

Advice of "discharge improved" is given to the Attorney of the King, to the Police Authorities, and to the Mayor of the Commune to which the patient belongs. During the trial period of the patient the family must send, through the Mayor, a medical certificate respecting the state of the said patient to the manager every four months.

When the manager declares an improved patient on trial has recovered, he gives advice of same to the Attorney of the King in order that he may obtain the "decree of definitive discharge" mentioned above.

If, during the trial period, it is found to be necessary for the patient to return to the asylum, he is readmitted on production of a simple medical certificate. The manager must at once inform the Attorney of the King, sending him a certified copy of this certificate.

Professor Leonardo Bianchi, in the speech already quoted, said:

"Now I think we ought to be interested in the insane person on his own account; because he is ill, we ought to conceive of the institutions for mental diseases as hospital institutions, and not only from the point of view of public safety, for the so-called persons who are dangerous to themselves and to others. Moreover, the law is contradicted by the fact in that all those who are sent to and received by a lunatic asylum when they are dangerous, if they are not perfectly cured, remain as inmates of the lunatic asylum even when they have become quiet. In this the law contradicts itself, because it is vain to prescribe internment only for dangerous lunatics when from the technical point of view it is not possible to judge as to whether they have become inoffensive, and when there is no means of obliging the families and other public institutions to take over those who were interned on account of a psychiatric episode which rendered them temporarily dangerous. And there is another reason of contradiction between the provisions of the law and the practical fact. As the judging of the inoffensiveness is not absolute, but relative, as regards insane persons who are not perfectly cured, there is no Director, however generous he may be, cultivated and of strong mind, who would expose himself to the rigours of the law by releasing alienated persons whom he judges to be no longer dangerous, who could be useful members of society, especially if they are farm labourers, and assisted by their families, because the law in the first paragraph of Art. 3 attributes to the Director of the lunatic asylum the responsibility for the acts which the discharged lunatic may at any time commit. In fact, in this it is stated: The Director may discharge a patient who is no longer in a condition of being dangerous, but only on his own responsibility.

"This factor, restrictive as to the discharge of insane persons from the psychiatric hospital, must be suppressed. These institutions must be allowed to breathe; the discharge of the patient should be left to the judgment of the Sanitary Authorities, who know, moreover, the surroundings to which the lunatic will or will not be entrusted."

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Spain :

Recovered and not recovered.—By the asylum and by the relatives, the Governor of the Province being notified.

Holland :

Recovered.—By the clinics, hospitals and asylums.

Not recovered.—By the clinics, hospitals and asylums, on trial. A special provision in the law enacts that an insane patient, though not recovered, may be discharged, if the cost of his maintenance is not forthcoming.

Germany :

Recovered.—By the clinics and asylums.

Not recovered.—(*a*) Patients can be discharged on trial.

(*b*) On the undertaking of his relatives to be responsible for him and all the consequences following his discharge. Regarding dangerous cases, on such an application being made, the Police Authorities are informed, and if they do not act within 3 weeks the patient must be allowed to go. If the Police decide against the discharge the patient remains in hospital.

The patient must be discharged, whether recovered or not—

(*a*) if "Guardianship" has been refused by a Court;

(*b*) if the legal representative demands discharge and the police sanction it.

The police are informed when it is proposed to discharge or allow out on trial cases admitted from prison or from the Courts.

As regards private institutions, a patient not a minor or under guardianship, on applying for his discharge in writing, the head of the institution, if he does not comply with the request, must transmit the same with a report to the Public Prosecutor.

Austria :

Recovered.—By the asylum. In "guardianship" cases the discharge must be notified to the "Competent Court."

Not recovered.—By the asylum to the care of relatives and on a suitable undertaking when necessary. In the latter case the Police Authorities, Political Authorities, District Captaincy and others must investigate the question whether the person giving the undertaking can carry it out and need to approve of the discharge. Harmless chronics can be sent to infirmaries and colonies.

STATE SUPERVISION OF MENTAL HOSPITALS.

France.—Supervision is exercised by the Minister of the Interior through the Prefect, the Mayor, the Attorney of the Republic, the

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Magistrates who visit the hospitals. The patients are regularly examined by psychiatric inspectors commissioned by the Prefect.

Italy.—Supervision is exercised by a Provincial Commission formed by the Prefect, the Provincial Medical Officer and a psychiatrist. The Commission visits the asylums once every year.

Professor Leonardo Bianchi remarks:

"The same thing has happened with the inspections of lunatic asylums; the medical man and Director of a lunatic asylum become for some time members of the Commission of Vigilance of other lunatic asylums; thus they are inspectors, but, in their turn, they must suffer inspection as the other institutions. It is needless to examine the objections as to this. On the other hand it is known by everybody that the inspections are made once a year; it is known that the Prefecture is preparing the inspections, and it is understood that everything goes well. But the character of the inspections is extraordinarily delicate as regards lunatic asylums, because it is a question not only of making sure whether the registers required by the regulations exist and whether things are kept in hygienic conditions, and the clinical records are kept, but to make sure that there are not kept in lunatic asylums persons who ought not to be retained there; the law is specially preoccupied with respect to the liberty of the citizens."

Spain.—Supervision is nominally by the Minister of the Interior, who delegates, through the Governor of the Province, the Provincial Sanitary Inspector to pay visits of inspection.

Holland.—The State provides two Inspectors of Lunacy, who visit the asylums whenever they wish.

Germany.—Supervision is exercised by the Chief President of the Federal State, and the asylums are inspected annually by a visiting Commission composed of a medical councillor, an experienced mental specialist, and, in some cases, a state medical officer. In some States these inspections have ceased during the past year or so.

Austria.—Psychiatric clinics are subject to the Minister of Education. There is only Provincial control. There are no State inspectors.

PSYCHIATRIC CLINICS AND SIMILAR PROVISIONS.

France.—In the cities and large towns the ordinary hospitals have wards, where patients suffering from mental disorders and who are not certifiable are treated.

Italy.—There are municipal psychiatric hospitals, and some clinics are separate institutions maintained by the State. Provision is inadequate for recent cases, because only dangerous and chronic patients can be received in the provincial asylums. It is proposed that some twelve to fourteen neurological clinics should take mental cases.

Spain.—General hospitals only have psychiatric clinics attached,

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but not all of them. Some of their regulations exclude mental cases.

Holland.—The clinic system is well-developed and encouraged. Psychiatric clinics are connected with universities and other medical clinics. Asylums also have attached "approved institutions" for uncertified cases. The doctors of the asylum are prohibited from certifying these cases if the necessity for such arises.

Germany.—Clinics are only in connection with the universities. In certain large general hospitals mental patients are temporarily admitted, but no prolonged treatment takes place. Patients who do not recover early are transferred to the asylums.

Austria.—Psychiatric clinics only exist in connection with three universities. Some of the large general hospitals receive mental cases temporarily, but only to pass them on to the clinics or asylums.

AFTER-CARE.

France.—Patients who do useful work while under care in the asylums receive remuneration. Part of this money is retained by the asylum and handed to the patient on discharge. Necessitous patients may, on discharge, receive assistance to help them while seeking employment.

There appears to be no "after-care" as we know it in England.

Italy.—There exists in connection with some asylums a society for the assistance of the insane poor, which, in addition to grants of money, has recently been providing the means for re-adapting the insane for outside life and employment. But these funds depend on private contributions, and are independent of the administration of the asylums. The Manager of the Asylum, however, is generally President of the Society.

Spain.—There is no "after-care" and no grant to necessitous patients on discharge.

Holland.—There are no grants from official funds to indigent patients on discharge. There are private funds, however, which help in this direction.

Germany.—Slight pecuniary assistance is given from public and private funds to assist patients on discharge. Patients may also be discharged to "Welfare Centres" in some cities. In some provinces there are "Associations for Aiding Discharged Mental Patients."

Austria.—No grants are made from public funds to poor patients on discharge. Private charities, such as that in Vienna known as the "Association for the Support of Persons Discharged from Curative Establishments," may assist some cases.

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AMERICA.

The lunacy laws in the various States of America differ so much that it is difficult to state any procedure in lunacy matters common to America. There is no Federal lunacy law, and the same remark applies to lunacy administration.

VOLUNTARY ADMISSIONS.

In 29 States voluntary admissions are permitted to the State hospitals. The patient must make the application himself and understand what he is doing, and must give in writing 3 to 10 days' notice of his desire to leave.

CERTIFICATION AND ADMISSION TO MENTAL INSTITUTIONS.

In 12 States "urgency cases" are cared for in jails.

There is some kind of emergency care pending examination and commitment in 16 States; also power to receive and detain for a limited time cases for treatment. The Massachusetts State Hospitals dealt with 1,929 of such cases during 1920. In many cities the Police and Health Authorities have great power of arrest and temporary commitment of the insane.

Certification, internment or commitment to a State or private hospital often involves a hearing before a jury. The application may be made by a relative or some responsible person, a trustee, Poor Law Authorities, etc. In Florida five reputable citizens must sign the petition. In most cases a summons is served on the patient who may or may not be present during the hearing, but such attendance is usually required. In some States the hearing is before a commission of two physicians, either sitting with the judge or reporting their findings to him. In other States there are special commissioners appointed to hear petitions. In one State two physicians examine the patient in the Court, and if they disagree the Judge decides.

These facts are sufficient to illustrate the different lunacy practices which obtain in America.

Broadly speaking, however, the internment consists of the following steps:

(*a*) The presentation of a petition before a Court, Local Authorities or Board of Commissioners. Petition is sworn to.

(*b*) A medical certificate as to the patient's mental state.

(*c*) A notice of the petition to the patient.

(*d*) The hearing of evidence, at which the patient is present, unless there are special reasons against it. The hearing may be before a jury or a commission.

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(*e*) The verdict.

(*f*) Judgment on the verdict, *i.e.*, commitment to a State hospital, private hospital, or to guardianship.

(*g*) The internment, or committal to care.

STATE OF NEW YORK.

The State of New York, as regards many of its social problems is comparable with greater London, and a comparison of the lunacy statistics relating to each reveals much the same incidence and type of mental disorder and because of these facts and of the fact that both places are populated by English-speaking races largely of Anglo-Saxon origin, the Lunacy Administration of New York State would appear to be of more practical interest to the Royal Commission than that relating to an entirely foreign country.

The State Hospitals Press of New York have recently published *The Insanity Law*, revised to July 1, 1924, from which the following facts are gleaned :

State Hospital Commission.

The administration of the insanity law as regards the care and treatment of insane persons is in the hands of the State Hospital Commission (referred to afterwards as the Commission), which is appointed by the State Governor by and with the advice and consent of the Senate. There are three Commissioners, as follows : one a reputable physician with at least ten years' experience of medical practice, which is to include five years' actual experience in the care and treatment of the insane in an institution for the insane ; one a legal practitioner of not less than ten years' standing ; one a reputable citizen. The medical commissioner receives an inclusive annual salary of 8,700 dollars and the other commissioners 6,200 dollars. The post of medical commissioner is tenable only during good behaviour, the others for a period of six years.

The Commission may appoint a medical inspector and one or more deputy medical inspectors and also administrative experts.

The chief duty of the Commission is the execution of the laws relating to the custody, care, and treatment of the insane (but not including feeble-minded persons and epileptics as such and idiots). Other duties and powers are the visitation, examination, inspection and investigation of mental institutions of every kind, public or private, and other places authorized by the law for the care of the insane (the State and private hospitals are visited at least twice a year) ; the adoption of rules and regulations for institutions, etc. ; the visitation of any place suspected of treating insane persons

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contrary to the law; the meeting once a year of the Managers of State Hospitals in conference; the creation of lunacy administrative areas, the provision of State hospitals, and the dealing with all matters of accommodation; the keeping of records of patients and the register of medical examiners, etc.

Generally speaking the Commission combines in itself the essential duties in this country of the local authority in relation to lunacy matters and of the Board of Control, and also those of the Minister of Health. It is answerable for its actions to the Governor and the legislature.

Managers of State Hospitals.

The Managers of State Hospitals are appointed by the Governor, by and with the advice and consent of the Senate, seven for each hospital, two of whom must be women, and all for a term of seven years. Members of State Assemblies are barred. Managers are to reside in the hospital district and are unpaid, but necessary travelling and other expenses are allowed.

They have the direction and control of the property and internal affairs of the hospital subject to the statutory powers of the Commission, except as otherwise provided by law. They maintain an effective inspection of the hospital, also hear and determine all charges and complaints against the Superintendent and other officers and employees of the hospital and report their findings to the Commission.

At monthly meetings the Superintendent reports on matters which are in this country usually brought to the notice of the Hospital Committees.

They have not the powers of the local authorities in England and Wales, and appear to be merely local representatives of the Commission and thus of the State.

Superintendent of a State Hospital.

He is appointed by the Commission subject to the approval of the Managers of the Hospital. He can be suspended by the Managers pending inquiries, and dismissed after inquiry with the approval of the Commission.

The Commission cannot dismiss a Superintendent, but may prefer charges against him to the Managers.

The Superintendent has to be a medical practitioner and to have had at least five years' experience in a mental institution.

His duties are similar to those which fall to a provincial medical superintendent in this country, except that he appoints and can dismiss all officers and employees of every grade and is entirely

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responsible for discipline. He discharges patients. He is sometimes treasurer of the hospital and he is always responsible for accounts and business matters. He has to hold at least two clinical staff conferences a week. The State Hospitals Superintendents have to meet in conference four times a year.

He has to establish, staff, and maintain out-patient departments and mental clinics within the hospital district.

Private Mental Institutions.

All private institutions for the care of the insane are licensed by the State, and the insanity law in most respects is equally applicable to both State and private institutions.

Commitment, Custody and Discharge of Patients.

The Order is by a Judge of a Court of Record of a county or city or a Judge of the Supreme Court of the district. Certificates of lunacy, which must show that the person is insane, are by two qualified medical examiners registered at the office of the State Commission and must be dated not more than ten days before the Order. Petitions are by relatives, officers of charitable institutions, overseers of the poor, etc.

At the hearing the presence of the patient can be dispensed with if such would be deterimental to his welfare.

Commitment, if patient be harmless, can be to the care of a relative or a *Committee of person*.

Medical examiners in lunacy are reputable physicians of at least three years' practical experience of their profession. They are given a certificate by a Judge of a Court of Record upon showing such qualifications as are prescribed by the Commission.

The Order must be acted upon within ten days.

The Superintendent may refuse to admit if the documents are not in order, or if he concludes that the person is not insane. In the latter case (if admitted) the Commission can discharge.

Cases requiring treatment or very dangerous cases can be admitted by the Superintendent on a certificate by two medical examiners pending an order being made.

The Superintendent of a State hospital on the request of a health officer can receive without order for a period not exceeding ten days a mental patient who needs immediate care. If not a suitable case the health officer must remove, and if not removed such a case becomes chargeable to his own district. Unless the patient signs a request to remain as a voluntary patient the health officer must take steps to have him examined. If found insane, an order is obtained, if found sane he must be removed within ten days.

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The Superintendent or physician in charge of any hospital or institution for the insane, except the Matteawan and Dannemore State Hospitals, may receive and retain a mental patient upon a petition by a relative, overseer of the poor, etc., on one certificate for ten days, but if the patient or a relative of the patient claim his discharge he cannot be detained for more than ten days except by order from a Judge of a Court of Record on the submission of a certificate of insanity by the medical superintendent or chief physician. By a similar section, at any mental institution a dangerous lunatic can be received on production of a petition and two certificates pending an order being made.

Duties of Local Officers in regard to their Insane.

County Superintendents of the poor, overseers of the poor, health officers and other city town or county authorities having duties to perform relating to the poor, except in the City of New York and in the County of Albany, are to notify the health officer of any poor or indigent insane or apparently insane person, and he is to see that proceedings are taken for the determination of his mental state and for his commitment to a State hospital. He is also to provide for his proper care, treatment and nursing in the meantime.

In the City of New York and County of Albany certain hospital authorities and commissioners of public welfare or charities are allotted similar duties in regard to the poor and indigent insane. They are also to take proceedings for the determination of the mental condition of any such person in their boroughs or county who comes under their observation, or is reported to them as apparently insane, and when necessary see that proceedings are instituted for the commitment of such person to a mental institution; provided that such report is made by any person with whom such alleged insane person may reside, or at whose house he may be, or by a relative or by any duly licensed physician or by any peace officer, or by a representative of an incorporated Society doing charitable or philanthropic work. When these Hospital Authorities or Commissioners are thus informed, it shall be their duty to send a nurse or a medical examiner in lunacy attached to the psychopathic wards of their respective institutions, or both, to the place where the alleged insane person resides or is to be found. If, in the judgment of the chief resident alienist of the respective psychopathic wards, or of the medical examiner thus sent, the person is in urgent need of care and treatment or observation, he shall be removed to such psychopathic ward for a period not to exceed thirty days, and the

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person or persons most nearly related to him shall be notified of such removal.

Discharge or certification and commitment to a mental institution, etc., must follow, before the expiration of thirty days.

In no case shall any insane person be confined in any other place than a State hospital or duly licensed institution for a period longer than thirty days or committed to any person, jail or lock-up for criminals.

Except in the City of New York and the County of Albany where provision exists, the proper authorities may provide a permanent place for the reception and temporary (thirty days') confinement, care and nursing of insane or alleged insane persons pending certification and commitment, and which shall conform in all respects to the rules and requirements of the Commission.

Insane Persons with Property who are Dangerous.

The onus of effecting confinement in cases dangerous to self or others is placed on relatives or *committees of person* which must be to the satisfaction of the health officer of the district and in New York and in the County of Albany to that of the authorities before cited. Failing relatives or *committees of person* acting, the health officer, or in New York, etc., the authorities mentioned, shall make or cause to be made, application to the Courts, and such a person may be arrested and removed to some comfortable and safe place. If an order of commitment has not been previously granted such shall now be applied for.

Under special agreement private patients may be admitted to State hospitals.

Voluntary Patients.

The superintendent of State hospitals or licensed mental institutions may receive and retain there as a patient any person suitable for care and treatment and who voluntarily makes written application therefor. Such an admission is notified to the Commission. A voluntary patient must give ten days' notice in writing of his intention or desire to leave.

Discharge of Patients.

The superintendent of a State hospital, on filing his written certificate with the Commission, may discharge any patient (except a criminal lunatic) who has recovered, and if not recovered and harmless to the care of his relatives or friends.

If the superintendent declines to discharge an unrecovered person upon request, the Court can be appealed to and the Judge may

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order, if he thinks fit, the discharge upon such security as he may think fit to demand.

The superintendent may *parole* a patient for a period not exceeding a year.

The Commission may discharge a patient improperly detained in any institution.

The same procedure as to discharge obtains as regards private institutions except that refusal to discharge an unrecovered person is subject to the approval of the Commission and the patient, under certain conditions, may be transferred and detained in a State hospital.

The Licensing of Private Mental Institutions.

A patient suffering from mental disease shall not be received and retained for treatment for compensation or hire in any institution for the care and treatment of persons suffering from any diseases other than mental, and all mental institutions must obtain a license from the Commission.

To obtain a license, plans, etc., of buildings it is proposed to use must be submitted to the Commission who examine the premises and satisfy themselves that they are suitable in all respects for the reception of insane persons before a license will be granted.

The Commission may from time to time visit private institutions to see that the terms of their licenses are being complied with.

This section of the insanity law does not apply to psychiatric wards or pavilions of general hospitals.

Subjoined is an abbreviated copy of the form of commitment prescribed by the Insanity Law of the State of New York.

STATE OF NEW YORK—STATE HOSPITAL COMMISSION.

FORM FOR THE COMMITMENT OF THE INSANE, PRESCRIBED BY THE STATE HOSPITAL COMMISSION PURSUANT TO THE PROVISIONS OF THE INSANITY LAW.

PETITION.

IN THE MATTER OF
AN APPLICATION FOR THE COMMITMENT OF
....
AN ALLEGED INSANE PERSON.

To the Hon........., justice or judge of the......court of the......of......
The petition of......, respectfully shows:

1. That he is a resident of the......of......, in the county of......, and that he is (if petition is made by a public officer, so state, and of what county, city or town)...... Or, That he is...... of......the alleged insane person.

2. That the alleged insane person now is at the house of......in the county of ......

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3. That the facts upon which the application is based are as follows:
(*The petitioner should state the facts observed by or the information known to him which would tend to show the existence of insanity, such as irrational acts or statements, attempts at suicide and attempts or threats to injure others. It is important to describe any change that has occurred in the behaviour and character of the patient.*)

....

....

4. That he verily believes it to be for the best interest of the said alleged insane person that an order be granted directing h commitment to an institution for the insane.

5. Upon information and belief that the said...... herein mentioned is not under a criminal charge or indictment.

6. Upon information and belief that the said......is the owner of the following property (real and personal):

....

7. Upon information and belief that......of......N.Y., the......(insert relationship as to father, mother, husband, wife or children), of said......, are the owners of certain property (real or personal) as hereinafter set forth:

....

Wherefore, upon the foregoing facts and the certificate of lunacy hereto annexed, your petitioner prays that an order be granted adjudging the said alleged insane person to be insane and committing h.. to an institution for care and treatment of the insane.

Dated......, 192..

No......st., city, village or town of......(Petitioner's signature and address).

STATE OF NEW YORK.
County of.......................... } *ss.:*
City, Town or Village of..............

......, being duly sworn, deposes and says that he has read the foregoing petition and knows the contents thereof, and that the same is true to the knowledge of deponent, except as to the matters therein stated to be alleged on information and belief, and as to those matters he believes it to be true.

......(Petitioner's signature).

Subscribed and sworn to before me this......day of......192..

....

....

CERTIFICATE OF LUNACY.

This certificate shall be filled out only by two qualified medical examiners.)

STATE OF NEW YORK
County of............................ } *ss.:*
City, Town or Village.................

(*a*) *History obtained by Physicians.*

Information furnished by......of......N. Y., who is a......of the patient.

1. Patient is at......, county of......, age......years; Nativity, state or country,......; if foreign, date of arrival in U. S....... Port of entry...... Steamship or line...... Is he a citizen of the U. S.?...... Is he a legal resident of New York State?...... If so, of what county, city or town?...... How long has he resided in New York State?...... If not a resident of New York State, where is h legal residence?...... Sex......; colour......; occupation......; single, married, widowed, divorced. Birthplace of father......; of mother...... Legal residence of father, if living...... Legal residence of mother, if living...... Has the patient had any insane relatives? ...... If so, state what relationship and whether paternal or maternal...... Have any of the relatives been in institutions for the insane?...... If so state

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relationship and give name and location of institution...... Has patient been considered as of normal mental standard?...... Institution or institutions where cared for in previous attacks, if any...... Has the patient had treatment for syphilis?......To what extent does he use liquor, tobacco, drugs?...... When did present attack begin?...... Was it characterized by depression, excitement, untidiness, destructiveness, suicidal or homicidal tendencies, delusions, hallucinations, etc.?...... What was first noticed?......

(b) Examination by Physicians.

(For method to be followed in examination see Instructions to Medical Examiners furnished by State Hospital Commission.)

Physical condition:..

Mental condition: The conduct of the patient (including statements made to us by others) has been.. ....

The patient said in our presence..

....

In our opinion the patient has the following dangerous tendencies:..............

We......a legal resident of......county of......State of New York and...... a legal resident of......, county of......, and State aforesaid, being severally and duly sworn, do severally certify and each for himself certifies, with the exceptions which are hereinafter noted, as follows:

1. I am a graduate of an incorporated medical college, and a qualified medical examiner in lunacy; a certificate of my qualifications as such examiner, or certified copy thereof, is on file in the office of the State Hospital Commission, and I have received from its secretary an acknowledgment of the receipt of the same.

2. *I have with care and diligence personally observed and examined on the date of this certificate, namely, on the......day of......192..,......now residing or being at......, in the county of......and as a result of such joint examination, find and hereby certify to the fact that he is insane and a proper subject for custody and treatment in some institution for the insane, as an insane person under the provisions of the statute.*

3. I have formed this opinion from the history of the case and my examination of the patient as given above.

4. *The reasons for considering this an emergency case are as follows:............*

....

5. That the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

......................M.D.
......................M.D.

Severally subscribed and sworn to before me this......day of......, 192......

....
....

Certificate of Justice or Judge relating to personal service.

Before the Hon..........., justice or judge of.......court; county, city or town of...... on the......day of......, 192....

IN THE MATTER OF
AN APPLICATION FOR THE COMMITMENT OF
....
AN ALLEGED INSANE PERSON

(1) I do hereby certify that, as appears by the affidavit of service submitted to me, personal service has been made upon the alleged insane person above named on......192.... and upon......who is......of the alleged insane person, or with whom he resides or at whose house he is (strike out words not required) by ......who is......of the city, town or village of......in the county of......

Or (2) I do hereby certify that I have dispensed with personal service, or, that

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I have directed substituted service as provided by law upon the person hereinafter named for the following reasons:

....

....
Justice or Judge of......Court of......

IN THE MATTER OF
AN APPLICATION FOR THE COMMITMENT OF
....
AN ALLEGED INSANE PERSON.

TAKE NOTICE that on the annexed petition of.......................... ....and the certificates of Doctors...... and......hereunto annexed an application will be made before the Honourable......, Judge of the...... Court at the......at......M., on the ......day of......192...., for an order committing you to the......as an insane person.

COUNTY OF.................................ss.

......being duly sworn, says that he is......of age, and that on the......day of......192...., at......he served a notice in the foregoing form of application for an order adjudging such person to be insane upon the person alleged to be insane, namely,......by delivering a copy of said notice and application and annexed petition and certificates of doctors personally and leaving the same with .... He further says that he knew the person served as aforesaid to be...... the person mentioned and described in the said application as an alleged insane person.

Sworn to before me this......day of......192.... ....
.... Signature of Server of Notice.

ORDER OF HEARING.

(If a hearing before a judge or referee be granted upon the demand of a relative or near friend of the alleged insane person or, upon the motion of the judge, the following form shall be used, otherwise it should be omitted):

Before the Hon.........., justice or judge of......court; county, city or town of......, on the day of......192....

IN THE MATTER OF
AN APPLICATION FOR THE COMMITMENT OF
....
AN ALLEGED INSANE PERSON.

An application for an order of commitment of the above alleged insane person based upon the petition of......, and upon a certificate of lunacy dated...... 192...., having been made, and (state degree of relationship, or if none, name of near friend)......having demanded a hearing upon such application, it is hereby

ORDERED, That a hearing on such application for an order of commitment of the above alleged insane person be had before......, at the......of......on the ......day of......192...., at......m., at which time testimony shall be heard touching the alleged insanity of the aforesaid person, and if it be deemed advisable said person may be examined either in or out of court.

The judge may (or if a referee be appointed, the referee herein named shall) hear such testimony and make such examination and report the same at once with his decision (or opinion) as to the insanity of such alleged insane person.

And that this order be served upon......, the petitioner, and the following named persons:

.... of...........................
.... of...........................
(Signature)...........................
Justice or judge of the......court... ..

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DECISION OF COURT AFTER HEARING.

(Decision of judge to be used only if a hearing is had.)

IN THE MATTER OF
AN APPLICATION FOR THE COMMITMENT OF
....
AN ALLEGED INSANE PERSON.

A hearing having been had upon the application of......for an order of commitment of the said person to an institution for the custody and treatment of the insane on the......day of......192...., and testimony having been taken as required by law, I do hereby decide that the said......is insane and should be committed to an institution for the custody and treatment of the insane.

Dated the......day of......192.... ....

Justice or judge of the......court...... of

ORDER OF COMMITMENT.

Before the Hon......., justice or judge of......court; county, city or town of ......on the......day of......192....

IN THE MATTER OF
AN APPLICATION FOR THE COMMITMENT OF
....
AN ALLEGED INSANE PERSON.

Upon the petition of......, dated......, 192....and a certificate made by two duly qualified medical examiners in lunacy, which certificate is dated on the ......day of......, 192...., and which is annexed hereto, and upon such other facts and information as were produced before me (or a referee appointed by me) at a hearing duly had, and being satisfied that the above alleged insane person is insane and a proper subject for custody and treatment in an institution for the insane, within the meaning of the statute, and that he is not in confinement under a criminal charge, it is therefore hereby

ORDERED, That the said......be and hereby is adjudged insane and that he be committed to (insert, correctly, official title of institution)............. an institution for the custody and treatment of the insane.

ORDERED, That the Superintendent of the......Hospital forthwith at the time of the commitment of......to said Hospital, forward a verbatim copy of the entire proceeding herein to the office of the Clerk of......County.

ORDERED, That the said papers so sent shall be sealed in the office of the County Clerk of......County, and be exhibited only to the parties to the proceedings, or someone properly interested, upon the order of the Court.

....

Justice or judge of......court of........

STATEMENT OF FINANCIAL CONDITION OF INSANE PERSON.

(If the order of commitment be directed to a State Hospital, the statute requires that the justice or judge shall append a statement as far as can be ascertained of the financial condition of the insane person and of the persons legally liable for h maintenance.) *(See section* 82 *of Insanity Law.)*

Real estate, location and estimated value..................................
....
Personal property and income of insane person herein and of his legally liable relatives ....
....

....

Justice or judge of......court of......

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CONCLUSION AND REFERENCES.

The *questionnaire* sent to the Corresponding Members of the Association, the replies to which form the main basis of this *précis* of evidence, was compiled by Dr. F. H. Edwards, of Camberwell House Hospital, London, S.E. 3.

The Corresponding Members referred to are:

Prof. Leonardo Bianchi, Manicomio Provinciale di Napoli, Musee N. 3, Naples, Italy.

Johannes Bresler, M.D., Sanitatsrat, Director of the Provincial Mental Hospital, Kreuzburg, Oberschlesien, Germany.

Dr. H. Colin, Secretaire General de la Société Medico-Psycologique de Paris, 26, Rue Vanquelin, Paris (Ve).

Dr. Buncke on behalf of Prof. Kraepelin, Professor of Psychiatry, The University, Munich.

Dr. Wilfrid Coroleu, Medico forense del distrito de la Barceloneta, Aribau, 31, pral, Chaflan Consejo Ciento de 7 a 8, Spain.

Dr. Wilhelm Falkenberg, Sanitatsrat, Direktor der Berliner, Torenanstalt, Herzberge, Berlin-Lichtenberg.

Dr. Giulio Cesare Ferrari, Director of the Manicomio Provinciale, Imola, Bologna, Italy.

Dr. Alexander Pilcz, VIII/2 Alserstrasse 43, Wien, Austria.

Prof. D. C. Winckler, Psychiatrisch-Neurologische Klinick der Ryos-Universiteit te Utrecht, Nicolaas Beetsstraat 24, Utrecht.

Reference to the following books and journals may be useful to the Commission:

"Baden Law Relating to the Mentally Afflicted," *Psychiatrisch-Neurologischen Wochenschrift*, 1910–11, vol. xii, p. 231.

"Saxony Law Relating to Lunacy," *Psychiatrisch-Neurologischen Wochenschrift*, 1913, vol. xv, p. 417.

"Die Entmundigungs, Verordnung und die Iwenaus'allen," by Dr. Berze, *Jahrbucher für Psychiatrie*, 1919, vol. xxxix, p. 47.

"Mental Hygiene and Prophylaxis in France," by Dr. H. Colin, *Journal of Mental Science*, 1921, vol. lxvii, p. 459.

"Legislative Restrictions in Connection with the Treatment of Incipient Insanity," by Dr. Wilfrid Coroleu, *Journal of Mental Science*, 1921, vol. lxvii, p. 470.

The Insanity Law. State Hospitals Press of New York, 1924.

The Care of Mentally Afflicted and Mentally Abnormal as Prescribed by Law, Ministerial Decrees, Municipal Orders and

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Jurisprudence, by Dr. Moeli. Halle a/Saale, Muhlweg 26: C. Marhold.

The Principles of the Comparative Laws for Lunatics, by Dr. Wyler. Halle a/Saale , Muhlweg 26: C. Marhold.

Annuaire de L'Internat en Médecine des Asiles Publics d'Aliénés, 1924. Paris: Vigot Frères.

L'Aliéné et les Atiles d'Aliénés au point d'une Administratif et Juridique, by Dr. Julian Raynier and Henri Beaudorien. Paris: Librarie le Francois.

Summaries of State Laws relating to the Insane. New York: National Committee for Mental Hygiene.

Mental Diseases: A Public Health Problem, by Dr. J. V. May. Boston, U.S.A.: Richard G. Badger, 1922.

Insanity and Law, by Dr. H. Douglas Singer and Dr. William O. Krohn. Philadelphia: P. Blakiston's Son & Co., 1924.

Part II.—Reviews.

The Ninth and Tenth Annual Reports of the Board of Control for the Years 1922 *and* 1923. (1)

Although we have been unable hitherto to comment on the Board of Control's reports for 1922 and 1923 we have by no means been unobservant of the Board's doings. Many pages of the last and the present volumes of the Journal have been devoted to the consideration of the reports of special committees, appointed either by the Minister of Health or by the Board, on matters of great importance in regard to the administration of mental hospitals and the care and treatment of the mentally afflicted, and this very largely has exhausted the space which could reasonably be allotted to the Board's activities.

In our previous review we expressed some concern as to the future of the Board, and whether it would survive the close scrutiny and, in many respects, unfair and prejudiced criticism then being directed to every aspect of our lunacy administration. The *finale* has been the appointment of a Royal Commission on Lunacy and Mental Disorder (England and Wales), and it is the hope of the Association that one outcome will be the strengthening of the Board, especially in medical personnel, and generally in regard to its power to enforce its views on matters touching the care and treatment of the insane. In this number is published the *précis* of the Association's evidence before the Royal Commission, in which are incorporated the Association's views as to a reconstructed Board under the name of "The Board of Mental Health." For years the Board's work has been handicapped by disabilities which we need not repeat (our pages have rendered them

(1) See note, January number, 1923, p. 99.

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