certificate from the doctor, together with a request from a relative as protects the house and without which a patient may not enter save voluntarily by his own written request, would sufficiently safeguard the rights of property, and in some measure maintain the peace of families. In this way we shall definitely arrive at the facts whether actual certification is necessary, unnecessary, cruel or injurious. Some form of certification in many cases does affect treatment favourably, absolute control being the first essential to treatment. The more perfect the legal control the more freedom the practitioner has for the treatment. This must be ensured by proper legal methods, since to deprive anyone of his liberty on incorrect diagnosis through insufficient observation is a matter to be studiously avoided, and the admission of such cases to licensed houses receiving the fully certified is not to be thought of. Neither should such licensee be permitted to have a house, separate though it may be, for the treatment of early cases.

The treatment in such sanatorium under notification would be in all respects as vigorously carried out to prevent insanity as for its care on full certification, and with the knowledge of control the case would be better treated. Some such scheme should be made law, because the treatment of the mentally afflicted by the inexperienced and under unsuitable conditions has developed to such an extent that something must be done.

Since legal formulary impedes early treatment, surely some statute law as for the State reception house might be made available for the approved notification sanatorium cases, and thus supersede the common law, alike for the benefit of the patient, the satisfaction of relatives, and the protection of the physician.

(1) Read at the Meeting of the Australasian Medical Congress held at Melbourne, October, 1908.

Receiving Houses. By W. ERNEST JONES, M.R.C.S.Eng., Inspector-General of the Insane for the State of Victoria.

THE use of Receiving Houses, that is to say, houses established specially for the observation of doubtful cases of mental disorder, is almost entirely of Australian origin, although something analogous exists, and has existed for many years in

England and Scotland, in the Lunacy Wards attached to the Workhouses, Infirmaries, and Poor Houses. The latter, however, do not fulfil all the uses that the Receiving House can be put to; neither are they independent institutions, nor do the terms for which patients can be received correspond.

The origin of Receiving Houses is to be credited to the enterprise of the late Dr. Norton Manning, for many years the Inspector-General of the Insane in the State of New South Wales, and their inception was due to the fact that the procedure for the reception of persons of unsound mind into an institution for the insane was so closely associated with the Police Court, that to be regarded as insane was much the same thing as being a criminal.

I have been deeply impressed with this fact when interviewed by patients in our State Hospitals for the Insane, inasmuch as very many bitterly complained that they have been hauled before the Court, although they had committed no crime, and yet they were subsequently committed on a charge of being a lunatic, although "of course there was nothing the matter with their brain." If there was any doubt, the person so charged was remanded to a prison or police station for medical observation.

To obviate this disgrace, the Receiving House was originated, and unquestionably it has most usefully fulfilled the functions for which it was created. It is possible also for the police of New South Wales to arrest and take to the Receiving House any case that is considered to be deranged in mind or wandering at large, without any preliminary steps in the way of certification. But it is necessary that the person so arrested should be taken before a court, in order that his detention may be confirmed or his discharge granted. In all this, the police element pervades the whole procedure.

In Victoria, the methods quite recently established by the Lunacy Act of 1903 are somewhat different, as, although the Act permits of the reception for observation of a person sent from a police court, it does not permit of a patient being admitted without some certificate from a medical practitioner; but it does permit of the reception of a doubtfully insane person through other channels than those of the police station or court, inasmuch as, on the application of any responsible person, accompanied by two modified medical certificates, a

person whose mental condition is apparently unsound may be admitted therein for a period of one month, which may under certain conditions be extended for a further period. It is obvious, therefore, that the provisions in Victoria permit of the use of the Receiving House for curative as well as observation purposes, and the Melbourne Receiving House about to be described has been arranged for that double purpose.

When I came to Australia, early in 1905, I found in Victoria three lunacy wards. They were small, unsuitable buildings, containing from four to six rooms, meagrely furnished, with very poor lavatory, bath, and kitchen accommodation, and with tiny walled-in back yards for airing courts. They were attached to, and staffed by the General Hospitals at Bendigo, Geelong, and Castlemaine. The latter two wards were but rarely used, and the last-named has since been given up. At Bendigo, some 60 to 80 patients were received annually, and were detained for a period of a few days up till a month, and only occasionally as long as six weeks. After having made various appearances at the police court, the patients sent to the ward for detention were either discharged, or fully certified and sent on to one of the State Hospitals for the Insane. About one third of these cases did not go on to the Hospitals for the Insane. The majority of those discharged recovered were cases of acute alcoholism, although of the number admitted to the lunacy ward, a few cases of attempted suicide were usually received. Such treatment as was possible was given, but only in the case of very evanescent disorders were recoveries returned.

The only other places in Victoria, where doubtful cases could be received were the gaols in the country and the Gaol Hospital in Melbourne, with this exception, that, in a few instances, patients were admitted into the wards of certain general hospitals, such as the Melbourne Hospital.

A visit to New South Wales convinced me of the fact that in the latter State their methods were the better, and that their Receiving House in Sydney was doing very good work, although it was dealing largely with police cases, alcoholics especially; and that whilst approximately one half of the police cases were discharged in a few days, quite an insignificant number of the patients admitted, under lunacy certificates, were treated for such a period of time as would enable them to be discharged as recovered. Let us take, for example, the year 1906: 752 police

cases were admitted and 347 discharged, whilst out of 171 admitted under lunacy certificates only 5 were discharged as recovered, whilst of the police cases, it appears that nearly one half were cases which would, in any event, have been sent on to the hospitals for the insane.

In organising and planning the Receiving House at Melbourne, an attempt has been made to deal with cases of mental disorder rather than the observation of police cases, and in this I think it may be claimed that some little success has been obtained, as will be seen from the accompanying statistics, and especially Table V, which sets forth the diagnosis of the mental disorder in the cases received.

In describing the Receiving House at Melbourne, one should perhaps mention first of all that a suitable site was difficult to obtain, and further that the area of ground was barely large enough, and the conformation of the site was of such a character that ideal orientation could not be obtained; neither could the original plan of the building be carried out in its entirety. However, the male side has been carried out faithfully, and the only discrepancies from the original plan (reproduced) appear on the female side.

The building consists of a central administrative block and two wings: in the former are contained a small compact residence for the officer in charge, offices, waiting rooms, a dispensary, and quarters for the matron in front. Behind are the kitchen, scullery, laundry, and boiler house. From the middle of the centre block broad, half-open verandahs lead into the wards, that is to say, verandahs on the weather side, half brick and glass, and on the other side open wire work. In the wards a central corridor lighted from the top has on one side dining rooms for the staff and patients, a scullery, a clothes store, and a bedroom for the charge attendant; on the other side is an examination room, with a bed, a bath, and lavatory basin. Next this there are two bedrooms for the staff, then four single rooms for quiet patients not needing continuous observation.

From the corridor two doors open, one into the day room and one into the dormitory. The dayroom is a very bright room, with ample windows and window seats. The dormitory is also very bright, and affords accommodation for twelve patients, and at the end of it are four single rooms, one being

Receiving House (Plan)
Royal Park Melbourne

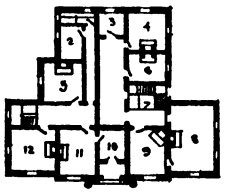
Scale:- 40 Ft to 1 Inch.

Ground Floor Rooms

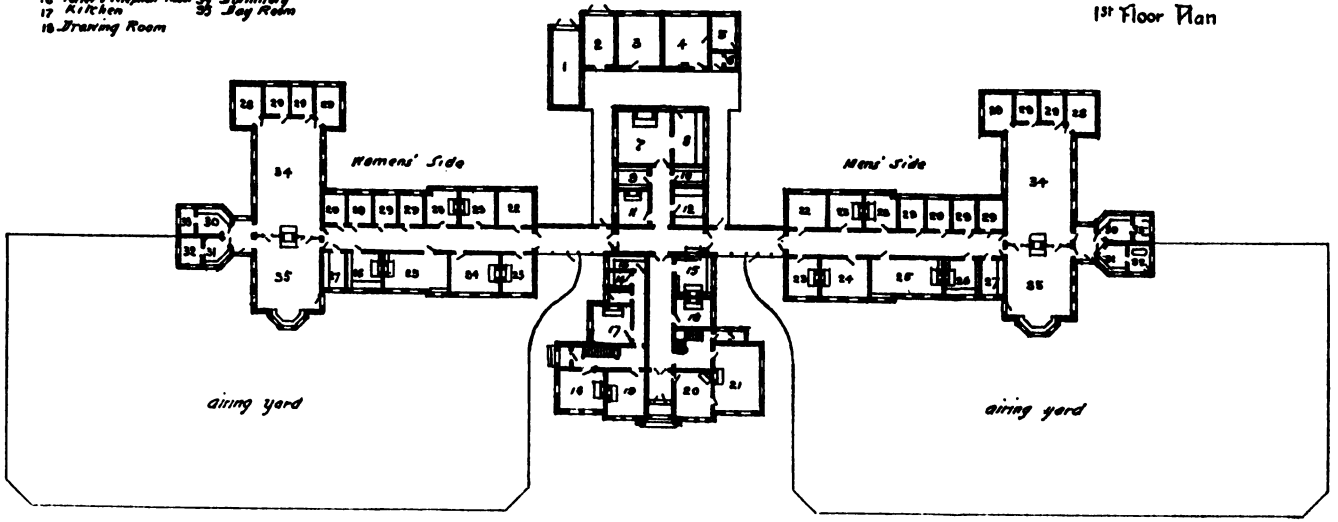
1 Boiler House
2 Coal House
3 Wash House
4 Laundry
5 Drying Room
6 W.C.
7 Kitchen
8 Scullery
9 China Pantry
10 Pantry
11 Cook's Laundress's Room
12 Stores.
13 Larder
14 Private Pantry
15 Surgery
16 Matron's Telephone-Room
17 Kitchen
18 Nursing Room
19 Dining Room
20 Waiting Room
21 Office
22 Examination Room
23 Attendants' Room
24 Attendants' Sitting Rm
25 Dining Room
26 Scullery
27 Linen Chest
28 Padded Room
29 Single Room
30 Urinal and Lavatory
31 Lavatory
32 Bath Room
33 W.C.
34 Dormitory
35 Day Room

1st Floor Rooms

1 Linen Cupboard
2 Bathroom
3 " " "
4 Cooks' bed Room
5 Bed Room
6 Laundress bedroom
7 Staircase
8 Matrons Sitting Room
9 " " Bedroom
10 Dressing Room
11 Bed room
12 Bed room



1st Floor Plan



Edward Jones.

padded and with a divided door. Both the dormitory and dayroom open into a well ventilated sanitary spur, the connecting corridor of which opens into an airing court. The spur contains a dressing room, a bath room with a plunge bath, as well as a nicely arranged shower bath, good lavatories, and w.cs. of the latest cantilever pattern. Everything has been done to make this block sanitarily perfect; the floors and walls nicely tiled, and a good pattern of lavatory basin adopted, a plunge bath fitted with Doulton safety valves, and the shower bath has a thermometer fixed in the delivery pipe to regulate the heat of the water. Between the dayroom and dormitories a very artistic lead glass screen has been placed, thereby giving brightness and decoration impossible to obtain with ordinary walls.

In the internal corridors wood pulp flooring has been laid on concrete, presenting a warm effect, and being practically noiseless. Great care has been exercised throughout in the ventilation, especially with the single rooms, the windows of which are provided with shutters which lock back into the side wall. The lighting is electric throughout, and telephones are placed everywhere. Outside the various blocks are fire hydrants, from which an excellent pressure is always obtainable. Internally, chemical extincteurs are relied on to deal with any fire emergency.

I have already said that the plan I proposed to build on had to be modified, and this for several reasons. The total cost of the building was nearly £14,000, and that may be taken as being a very high figure. I had hoped to have had this building erected for some £10,000 to £11,000; but it was found necessary to modify in some particulars our requirements, and this was done principally in dealing with the female wing—for, taking Darlinghurst and its numbers as a guide, I found that the number of female admissions was barely half that of the males. I have occasionally to regret that I permitted any departure from my original plan. I must confess that I have made a mistake in not having a verandah built along the western front of the wards; in omitting this I was biassed by the fact that the verandahs in most of our State Hospitals, built, as they are, on both sides of the long gallery wards, cut off so much light and interfere so much with the through ventilation, that I determined (wrongly I think now) to dispense with their assistance.

Statistics.—I have taken the year that has elapsed since the Receiving House was opened, that is to say from September 24th, 1907, to September 23rd, 1908, inclusive. We have admitted 339 cases (184 males, 145 females), but of these 3 males and 7 females were readmissions during the year, so that we have dealt with 329 persons. Of the 339 cases, 128 (72 males and 56 females) have been discharged recovered, 2 males and 2 females relieved, and 3 males and 2 females not improved. One patient (a male) died; he was admitted very seriously ill, and died a few hours after admission. One hundred and eighty-four (100 males, and 84 females) were transferred to the State Hospitals, so that we have 128 successes to set against 184 failures, and when we consider that among the latter number we have had 26 general paralytics, a few imbeciles and senile dements, and a considerable number of epileptics (21), I think we may assume that the Receiving House has (considering the fact that a two months' stay is the longest period possible) carried out its intention in a reasonably satisfactory manner.

With regard to the cases received: Mild cases of mania and melancholia have given us good results, and I would remark in passing that we admitted no less than 101 cases of suicidal intent, some of them undoubtedly severe cases, and of these two men and one woman sometime subsequently to discharge succeeded in encompassing their own destruction. Our best results were from cases of alcoholism, principally amongst the men, and hystero-mania amongst the women.

As to causation: As usual, in this State, heredity ranks very low, only 44 cases out of 339 giving a hereditary history of insanity. Alcoholism is the most important cause: 58 cases show alcohol as a factor. Ill-health and mental anxiety or overwork account for 54 and 28 cases respectively. Previous attacks were noted in 27 cases. The average age of the admissions was 42 years.

Conclusions.—I feel that the institution of Receiving Houses in English towns, having a population of 100,000 or more, would prove the solution of many of the difficulties of dealing with recent cases of mental disorder amongst the working classes. Such a house could be run in connection with an infirmary or a general hospital, or even an asylum for the insane, if it be reasonably accessible to the centre of population; but it is

RECEIVING HOUSE, ROYAL PARK.

TABLE I.—*Showing the Admissions, Re-admissions, Discharges, and Deaths, during the Year ending 23rd September*, 1908.

	M.	F.	Total	M.	F.	Total
Cases Admitted:						
First Admissions	184	145	329			
Not First Admissions (Readmissions) ...	3	7	10			
Total Cases Admitted during the year				187	152	339
Total Cases under care during the year				187	152	339
Cases Discharged:						
Recovered	72	56	128			
Relieved	2	2	4			
Not Improved	3	2	5			
Died	1	0	1			
Transferred from the Institution	100	84	184			
Total Cases Discharged and Died during the year				178	144	322
Remaining in the Asylum 23rd September, 1908				9	8	17

TABLE II.—*Showing the Length of Residence in those Discharged Recovered, and in those who have Died, during the twelve months ended 23rd September*, 1908.

Length of Residence.	Recovered.			Died.		
	M.	F.	Total.	M.	F.	Total.
Under 1 month	55	41	96	1	0	1
1 month and under 2 months ...	17	15	32	0	0	0
Total	72	56	128	1	0	1

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TABLE III.—*Showing in Quinquennial Periods the Ages of those Admitted, Recovered, and Died, during the Years 1907—08, and of those remaining on 23rd September, 1908.*

Ages.	The Admissions.			Recovered.			The Deaths.			Patients Resident, 23rd September, 1908.		
	M.	F.	Total.	M.	F.	Total.	M.	F.	Total.	M.	F.	Total.
5 years and under 10 years												
10 ,, 15 ,, ...	1	1	2	1	...	1						
15 ,, 20 ,, ...	6	3	9	2	...	2	1	...	1			
20 ,, 25 ,, ...	17	21	38	8	9	17	...	...	...	2	1	3
25 ,, 30 ,, ...	14	14	28	5	3	8	...	...	...	...	2	2
30 ,, 35 ,, ...	18	16	34	6	7	13	...	...	...	1	1	2
35 ,, 40 ,, ...	33	21	54	10	10	20	...	...	...	2	3	5
40 ,, 45 ,, ...	24	24	48	10	12	22	...	...	...	2	1	3
45 ,, 50 ,, ...	36	23	59	15	10	25						
50 ,, 55 ,, ...	12	14	26	4	3	7	...	...	...	1	...	1
55 ,, 60 ,, ...	9	3	12	4	...	4	...	...	...	1	...	1
60 ,, 65 ,, ...	3	2	5	...	1	1						
65 ,, 70 ,, ...	6	5	11	5	1	6						
70 ,, 75 ,, ...	4	1	5	1	...	1						
75 ,, 80 ,, ...	4	1	5	1	...	1						
80 ,, 85 ,, ...	...	1	1									
85 ,, 90 ,, ...	...	2	2									
90 ,, 100 ,, ...												
Unknown												
Total	187	152	339	72	56	128	1	...	1	9	8	17
Mean Age	43	39	42	41	38	40	18	...	18	37	31	34

TABLE IV.—*Showing the Probable Causes of Insanity in the Patients Admitted during the Year ended 23rd September*, 1908.

CAUSES OF INSANITY.	NUMBER OF INSTANCES IN WHICH EACH CAUSE WAS ASSIGNED. Admissions { No. of Cases— Males—187. Females—152. Total—339.											
	As Predisposing Cause.			As Exciting Cause.			As Predisposing or Exciting (where these could not be distinguished).			TOTAL.		
	M.	F.	Total	M.	F.	Total	M.	F.	Total.	M.	F.	Total
MORAL—Domestic Trouble (including loss of relatives and friends) ...	...	...	...	2	10	12	...	...	...	2	10	12
Adverse Circumstances (including business anxieties and pecuniary difficulties)	...	...	...	6	3	9	2	1	3	8	4	12
Mental Anxiety and Worry (not included under the above two heads), and Over Work	1	...	1	12	9	21	5	1	6	18	10	28
Religious Excitement												
Love Affairs (including seduction)	...	...	...	2	3	5	...	...	...	2	3	5
Fright and Nervous Shock	...	...	...	...	12	12	...	1	1	...	13	13
PHYSICAL—Intemperance in Drink	1	1	2	40	9	49	6	1	7	47	11	58
Intemperance (sexual)	...	...	...	1	2	3	...	...	...	1	2	3
Venereal Disease	5	...	5	3	1	4	2	...	2	10	1	11
Self Abuse (sexual)	...	1	1	4	...	4	6	...	6	10	1	11
Over Exertion	...	1	1	...	...	...	...	...	...	...	1	1
Sunstroke	1	...	1	...	...	...	1	...	1	2	...	2
Accident or Injury	2	...	2	5	2	7	1	...	1	8	2	10
Pregnancy												
Parturition and the Puerperal state	...	...	...	...	3	3	...	...	...	...	3	3
Lactation												
Uterine and Ovarian Disorders	...	1	1	...	3	3	...	...	...	...	4	4
Puberty												
Change of Life	...	9	9	...	4	4	...	2	2	...	15	15
Fevers	...	...	...	2	...	2	...	...	...	2	...	2
Privation and Starvation	...	...	...	3	1	4	...	...	...	3	1	4
Old Age	1	1	2	1	3	4	3	2	5	5	6	11
Other Bodily Diseases or Disorders	2	7	9	16	22	38	6	1	7	24	30	54
Previous Attacks	13	13	26	...	1	1	...	...	...	13	14	27
Hereditary Influences ascertained (direct and collateral) ...	20	24	44	...	...	...	...	...	...	20	24	44
Congenital Defect ascertained	...	1	1	3	7	10	5	...	5	8	8	16
Other ascertained Causes	...	2	2	4	4	8	4	...	4	8	6	14
Unknown	...	...	...	...	...	...	35	22	57	35	22	57
Total	46	61	107	104	99	203	76	31	107	226	191	417
Deduct for combined causes	...	...	...	...	...	...	...	...	...	39	39	78
Total Admissions	46	61	107	104	99	203	76	31	107	187	152	339

TABLE V.—*Showing the Form of Mental Disorder on admission in the Admissions, Recoveries, and Deaths for the year 24th September, 1907, to 23rd September, 1908, inclusive, and the Form of Mental Disorder of the Inmates on 23rd September, 1908.*

Form of Mental Disorder.	Admissions.			Recoveries.			Deaths.			Remaining on Books.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
I. Congenital or Infantile Mental Deficiency (Idiocy or Imbecility) occurring as early in life as it can be observed.												
1. Intellectual:												
(*a*) With Epilepsy	3	2	5	...	1	1						
(*b*) Without Epilepsy ...	7	3	10	2	2	4	...	...	...	2	...	2
2. Moral.												
II. Insanity occurring later in life.												
1. Insanity with Epilepsy... ...	11	5	16	5	...	5	...	..	...	1	...	1
2. General Paralysis of the Insane	21	5	26	...	...	...	...	...	...	1	...	1
3. Insanity of the grosser Brain lesions	3	1	4									
4. Acute Delirium (acute Delirious Mania)	1	...	1	1	...	1						
5. Confusional Insanity.												
6. Stupor	3	2	5	...	1	1	1	...	1			
7. Primary Dementia	12	10	22	5	2	7	...	...	...	...	1	1
8. Mania:												
(*a*) Recent	17	23	40	9	9	18						
(*b*) Chronic	2	...	2	1	1	2						
(*c*) Recurrent	6	6	12	1	3	4	...	...	...	1	...	1
9. Melancholia:												
(*a*) Recent	30	32	62	14	9	23	...	...	...	2	2	4
(*b*) Chronic	2	3	5									
(*c*) Recurrent	6	4	10	2	2	4						
10. Alternating Insanity.												
11. Delusional Insanity:												
(*a*) Systematised	13	16	29	4	5	9	...	...	...	2	...	2
(*b*) Non-systematised ...	14	14	28	2	6	8	...	...	...	...	3	3
12. Volitional Insanity:												
(*a*) Impulse	3	2	5	1	2	3						
(*b*) Obsession.												
(*c*) Doubt.												
13. Moral Insanity.												
14. Dementia:												
(*a*) Senile	7	8	15	2	...	2						
(*b*) Secondary or Terminal...	5	2	7	2	...	2						
15. Neurasthenia	1	...	1	1	...	1						
16. Alcoholism	18	7	25	18	7	25						
17. Toxic Insanity and Narcomania	1	1	2	1	...	1	...	...	...	...	1	1
18. Hysteria and Hystero-mania...	...	6	6	...	6	6	...	...	...	...	1	1
19. Amnesia...	1	...	1	1	...	1						
Totals	187	152	339	72	56	128	1	...	1	9	8	17

N.B.—The discharge, as recovered, of imbeciles and epileptics may appear an unusually optimistic thing, but in all cases so discharged these patients were so well as to be able to resume their places in Society, and to return to the work which they had previously been performing.

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essential that the medical officer in charge should have had a thorough training in the treatment of mental disorders; and in passing one might mention that such a necessity would provide openings for the assistant medical officers of large institutions, who have at present far too long a period of waiting to look forward to ere they can meet with a reasonable reward. A very desirable adjunct to the Receiving House would be a convalescent home in the country, wherein the recently recovered could be received for an easy probationary period, before returning to the struggle for existence. I feel sure that the institution of these methods would seriously reduce the number of the insane in the asylums and State hospitals of English-speaking communities, and incidentally lower the cost of the maintenance of the chronic insane, as there would be less necessity to provide elaborate accommodation in the large State asylums.

I attach statistics drawn up in much the usual way to show the number of patients admitted and discharged, as well as the causes of, and kinds of, mental disorder amongst our patients.

Insane Movements and Obsession.(1) By J. LOUGHEED BASKIN, L.R.C.P.Ed., Medical Superintendent, Fisherton House.

ONE cannot visit the wards of an asylum without realising that there are many types of mental disease, each with its own symptoms and physical signs, and that intercurrent and overlapping affections of the mind are especially common; thus, in maniacal excitement you may find delusions, in paranoia you find delusions with marked impairment of judgment, in general paralysis you get, in addition to physical signs, delusions, which vary from the facility of the early period to the more difficult mentation found in the advanced age, so that here we have three distinct types of disease, each of which may have delusions, and the delusions may all be of the exalted variety—the patients may consider themselves gods, kings, or mighty personages. The progress of research has had more difficulties to contend with in the subject of mind than in almost any other. It is a subject which is intangible, yet its reactions can be timed.