ought not, in the first instance, to be sent to asylums, such as the mania from drink, the mania of hysterical excitement, the dementia of habitual intemperance, the dementia and melancholia directly due to want, a group of cases which, with few exceptions, when supplied with warmth, wholesome food, and deprivation of alcohol, rapidly recover. Amongst the well-to-do classes, such of these cases as arise are never sent in hot haste to an asylum. No sensible practitioner would ever advise such a course. As a fact, every man in large practice sees, in the course of a year, numbers of such cases, and never dreams of suggesting an asylum. He would gravely err if he did. Such cases cannot, as a rule, be kept in the hovels of the destitute poor. Why should not the same discretion be allowed to the medical attendant on a pauper as is the daily practice of private practitioners? Why should not such cases be sent to the workhouse for supervision. There is no mystery or magic in the wards of an asylum. To all intents and purposes, the lunatic wards of a well-regulated workhouse are as suitable as similar wards in an asylum. But, no! this, say the Commissioners, cannot be allowed; and, I suppose, that if any responsible person were to inform a relieving officer that some old woman was out of her wits, it would be his duty to take her before a magistrate, and he, having called to his assistance a medical man, would send the said old woman to an asylum. This is the course which every relieving officer would take who is nervously anxious lest he should be prosecuted for neglect of duty. What I contend for under this head is, that there should be some careful and skilled discretion exercised, in the first instance, as to who should and who should not be sent to an asylum.

Apart from the question of economy, there is another advantage arising from the detention of harmless cases in workhouses, namely, the facilities which are afforded for the frequent visits of friends, for occasional holidays, all of which serve to keep alive that sympathy between the sick and their relatives which is so desirable.

There is one other subject relating to this question to which I must refer, seeing the influence it undoubtedly exercises in inducing Guardians to send hopeless cases to asylums, and to keep them there. I allude to the grant from funds provided by Parliament of 4s. a head on all pauper lunatics, inmates of asylums. I have no sympathy with this kind of assistance to local rates as a general principle; but with this I have no concern. The tendency of all such aids seems to me to lead to the diminution of local responsibility, and to impair the efficiency of local self-government. In this particular case it affords a direct inducement to needlessly increase the number of inmates in our asylums. As an example of what it does, I am told that not long ago a union whose workhouse was overcrowded, and who found an asylum that was not, sent all their lunatics to the asylum rather than incur the cost of increasing their accommodation, and thus in the most costly and most extravagant manner secured the space they required.

If every bed in an asylum costs from two to three hundred pounds, then every case needlessly sent from a workhouse costs, in addition to the increased charge for maintenance, a rental of from ten to fifteen pounds a year for building, ten pounds is recouped to the union at the expense of fifteen to the county. The charges of one authority are reduced by increasing those of another, to more than the same amount. Another evil arising from divided administration.

The questions which in this paper I desire to submit to the Conference are:—

1. That it is the duty of Boards of Guardians to provide for all their sick, including lunatics, whether in asylums or elsewhere, such treatment as they may require, and that for cases of acute and curable insanity, asylums afford the best provision.
2. That for chronic and incurable cases of insanity it is their duty to reduce the cost of maintenance to as low a level as is consistent with their proper care and custody.
3. That the provision of suitable wards and attendants in connection with workhouses affords the best and most economical method of providing for the wants of this class.
4. That some supervision should be exercised over the class of cases sent to asylums.
5. That all pauper lunacy, certainly that in workhouses, should be placed under the direct control of the Local Government Board, who by the aid of skilled inspection should bring the management of pauper lunacy into harmony with the principles of the Poor Law, having due regard to the requirements of the sick on the one hand and the interests of the ratepayers on the other.

TESTIMONIAL TO DR. BRUSHFIELD.

In our last issue we announced the retirement of Dr. Brushfield from the Surrey Asylum. He has not been allowed to quit his post without several Testimonials which must be gratifying to him as a proof of the regard in which he has been held by those who knew him when engaged in the fulfilment of his daily duties. On the last day of March an address was presented by the officers and staff of the asylum, accompanied by a claret jug and candelabra as a testimonial of their regard, "to help to keep us and the time you have spent here always in your remembrance, and testify to your children after you the high esteem in which their father was held."

https://doi.org/10.1192/S0368315X00227527 Published online by Cambridge University Press

In May Dr. Brushfield's numerous friends in the county, headed by the Vicar of Woking, made a handsome presentation to him, consisting of valuable plate, and an arm chair in which we hope the late Superintendent of Brookfield will enjoy the *otium cum dignitate* which he has justly earned. We hope it has been constructed on the principles which Herbert Spencer says ought to be followed in making a chair. Dr. Brushfield replied on both occasions in feeling, and we need not say fitting terms.

Correspondence.

"PROPOSED STATISTICAL TABLES."

To the Editors of THE JOURNAL OF MENTAL SCIENCE.

GENTLEMEN,—Such a change as that proposed by adoption of the Tables lately presented by the Statistical Committee of the Psychological Society warrants my addressing you in this form, for by this means my remarks will reach my fellow-superintendents, and they, as those who make the returns, are chiefly interested in this subject.

In 1864 a committee was appointed to draw up statistical tables for our Society. In 1865 they presented a report and six tables. In 1867 a second report was issued, with an increase of four tables. At that period 27 asylums had already adopted these tables. In 1877, taking as a whole the English County, City, and Borough Asylums, and the Scotch Royal and District Asylums, of 83 asylums issuing reports 52 had adopted these tables, the Irish and the Scotch District and Royal Asylums being the principal defaulters in their adoption. At present, without investigating closely into the matter, I am aware that one district asylum in Scotland, and at least two Royal asylums, do not use the tables.

The Tables of our society are fairly adopted. They were drawn up by good men, and they afford a certain amount of information. They should only be superseded after consideration, and on the recognised belief that the new tables are greatly superior.

The following are manifest advantages in the new tables: That they deal with *persons*, not *cases*, that they give the deaths at the different ages, and that they show the ages of the patients resident at the end of the year.

The following are defects: The optional character of Table 11a. If of use, it should be numbered and included in the series; if not valuable enough for this, it should not exist. Statistical information of this nature derives its chief value from the number of returns made in a uniform method preventing small errors from vitiating totals.

Table XI. subdivides the patients in a valueless mode. The first division into curable and incurable is clearly antagonistic to what should be, from a physician's point of view, and some of the other subdivisions are unworkable.

So much for defects. Now for omissions. It strikes me that in this proposed series of tables; statistics of admissions, discharges, and deaths, have obscured the view point of the physician, anxious about causation and the variety of insanity, its connection with physical disease, and its termination. It should be clearly stated whether the cause of death was ascertained by post-mortem examination or merely conjectured. Some uniform return should surely be made of the form of insanity in those admitted. A table showing the bodily condition of those admitted would be useful, with the special connection of some diseases noted, such as phthisis, cancer, &c. A table showing hereditary predisposition where it exists, its degree, and whether paternal or maternal, would be most valuable.

https://doi.org/10.1192/S0368315X00227527 Published online by Cambridge University Press