SOME DEVELOPMENTS, LEGAL AND ADMINISTRATIVE, IN MENTAL TREATMENT.*

By R. H. CURTIS,
Chief Officer of the L.C.C. Mental Hospitals Department.

WHEN I first began, more than thirty years ago, to be interested at first hand in the administration of the law relative to the care of the mentally afflicted, the main statutory provisions for England and Wales were the consolidating Lunacy Act of 1890 and its amending Act of 1891, supplemented by a few earlier statutes dealing with the disposal of insane soldiers and criminal lunatics, and the public chargeability of the insane under the Poor Law. Public hospitals for mental cases were the county and borough lunatic asylums, supplemented, for the needs of persons who could pay, by the licensed houses (the number of which, by direction of the Act of 1890, could not be increased) and the registered hospitals, which also made limited provision for free cases. There was little special provision for the needs of the mentally defective as distinct from the mentally sick. There were five idiot asylums, charitable institutions of a good many years' standing, and a few groups of homes established by voluntary effort for the education and training of the feeble-minded. An Act passed in 1899, "to make better provision for the elementary education of defective and epileptic children", for the first time enabled education authorities to ascertain what children of school age, not being on the one hand imbecile and on the other merely dull and backward, were unable to benefit by instruction in a public elementary school, but could benefit by instruction in special classes or schools, and to provide special classes or schools accordingly for such cases and for epileptic children. Apart from these provisions, care for the congenital case of mental defect could be provided only if the defect amounted to idiocy or imbecility, either in the county or borough asylum, or, if the case was quiet and harmless, in the workhouse. London was in an exceptional position as regards the last-named possibility, because for the Metropolitan area a special Poor-Law body, the Metropolitan Asylums Board, had been established under an Act of 1867, and this Board had, as one of its functions, the provision centrally, on behalf of the several London Poor-Law parishes and unions, of accommodation for "such harmless persons of the chronic or imbecile class as could be lawfully retained in a workhouse". The Board could not provide for "dangerous or

* The Inaugural Address for the second R.M.P.A. Refresher Course held at the L.C.C. Central Laboratory, November, 1937.

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

curable persons . . . such as would under the statutes in that behalf require to be sent to a lunatic asylum". The result was that in London a great many idiot and imbecile children, and a great many feeble-minded children of relatively high grade, who escaped the mesh of the education authority's net because they were being dealt with at the charge of Poor-Law authorities, were sent to the care of the Metropolitan Asylums Board and grew to adult stature in the institutions which the Board provided for them. But the Board also received, as "harmless chronic" patients, large numbers of persons who were suffering merely from the natural mental decay associated with advanced age, whom the Boards of Guardians were glad enough to get rid of from their institutions. Still, the provision made by the Metropolitan Asylums Board, specialized as it was, did not prevent the beds in the London county asylums from being occupied by precisely the same kinds of patients as the Board received. To the county asylums, of course, were sent the acute cases of mental disease whom the Board were precluded from receiving because they were "dangerous or curable"; but the county asylums received in considerable numbers persons who were mentally defective rather than mentally disordered, though at rather later admission ages than the Metropolitan Asylums Board's juvenile admissions, and they also received, as the subjects of reception orders, old people whose only trouble was the dementia of senility, whose admission as "certified lunatics" came to be regarded, more and more, as an administrative scandal. In fact the infirmary wards of the county asylums were largely occupied by aged patients, some of them, of course, those who had grown old in the institutions, but many of them persons who had not needed care until old age had made it difficult for them to be kept at home. And it is no exaggeration to say that a large proportion of the able-bodied chronic working patients in the county asylums were feeble-minded persons who, even if they once had suffered from some supervening psychosis, had become stabilized and institutionalized and were not at all the kind of case for which a county asylum was supposed to be provided, though they were by no means unwelcome inmates from the selfish standpoint of the asylum administrator, who found in them hard-working and economical substitutes for paid staff.

A Royal Commission, appointed in 1904 to consider existing methods of dealing with idiots and epileptics and with imbecile, feeble-minded or defective persons not certified under the lunacy laws, and to report as to necessary amendments of the law, submitted its report in the summer of 1908, and the practical outcome of the Commission's recommendations was the Mental Deficiency Act of 1913. This Act for the first time made it the duty of local authorities (county and county borough councils) to *ascertain* what persons within their area are "defective" within the meaning of the Act, in contra-distinction to being insane, and to provide supervision for them at home, or if that form of care is inadequate to secure that they are sent to institutions

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

for care or are placed under suitable personal guardianship. A defective person, under this Act as subsequently amended and to some extent amplified in 1927, is either an idiot or an imbecile, of low mental grade, or a feeble-minded person of rather higher grade, or a "moral defective" whose mental deficiency may not be very noticeable, but is coupled with strongly vicious or criminal propensities and calls for "care, supervision and control for the protection of others". Mental defectiveness is limited for statutory purposes to "a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury". If a defective child is of school age the primary responsibility for care and training rests with the local education authority, whose duty it is to provide special schools or classes for such children—if necessary, residential schools—but if a defective child of school age proves to be incapable, either by extremity of mental defect or by detrimental behaviour, of deriving benefit from the education authority's provisions, the education authority must give notice of the case to the local authority, who must then deal with the case under the Mental Deficiency Acts. Defective children of less than school age, i.e., not yet seven years old, are, from the start, the responsibility of the local authority under the Mental Deficiency Acts.

Now this recognition of the mentally defective as a class to be dealt with apart from the insane has, during the twenty-four years which have passed since the Act of 1913 appeared on the Statute Book, made a good deal of difference to the administrative problems attending the care and treatment of the mentally disordered. Defectives in counties and boroughs in which the Mental Deficiency Acts are being seriously administered are ascertained at relatively early ages, are educated, if they are capable of education, on lines specially adapted to their limitations, and if, during or at the end of their school life, they are found to need other forms of institutional care, those forms are provided, apart from the mental hospital, in special colony institutions. That, at any rate, is the case in London. The defective is no longer left to be the facile prey of unscrupulous exploiters or the victim of evil associations; he or she is saved from the anti-social influences which in the old days led through conduct-disorder to prison and the asylum; and the new specialized colonies for defectives which are springing up are relieving the mental hospitals from the need to house defectives who formerly were certified as insane, perhaps on the strength of a mild psychosis, but thereafter remained under permanent mental hospital care largely because there was no other way of securing society against the nuisance of the defective at large, though within the mental hospital walls that defective was amenable enough and not, in the ordinary sense of the word, "insane". The low-grade idiot or imbecile never was, to the same extent as the feeble-minded, an "asylum" problem; such cases were always the burden of the workhouse rather than the mental hospital, and still in many parts of the country are housed, under provisions made in the Mental Deficiency

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

Acts themselves, in workhouse accommodation specially set aside and approved for the purpose. In London, special accommodation provided originally by the Metropolitan Asylums Board, and now added to the general body of institutional accommodation available for various forms of mental abnormality under the management of the London County Council, is set apart as "approved" accommodation to supplement the accommodation provided in "certified institutions" for defectives by the Council itself. For purposes of general administration of the Mental Deficiency Acts in London the two forms of accommodation are practically indistinguishable.

Still, the passing of the Mental Deficiency Acts, though it has reduced and in time will further reduce the number of chronic able-bodied working patients in county and borough mental hospitals, has not greatly affected the population of those hospitals otherwise. That has been done to a much more noticeable degree by another statute to which attention must now be paid—the Mental Treatment Act, 1930, which came into force on January 1, 1931, rather less than seven years ago, as the outcome of recommendations made by a Royal Commission, appointed in 1924, which reported in 1926. The new Act extended to the county and borough mental hospitals of England and Wales the power to receive voluntary patients which formerly had been confined to licensed houses and hospitals, and it created a new class of "temporary" patient, a person without ascertainable volition who may be received without formal reception order, but on the written application of a responsible relative, supported by two independent medical certificates. It is necessary to discuss these two classes of patient somewhat closely.

To deal first with the *temporary patient*. Section 6 of the Act of 1930 makes it the *duty* of every local authority to investigate the needs of its area, and to take necessary steps to provide and maintain suitable accommodation for the reception of temporary patients. Local authorities are merely *empowered* to receive and lodge and maintain and treat voluntary patients in any institutions under their control on such terms and conditions as to payment or otherwise as may be agreed. It would seem, therefore, to have been contemplated by the legislature that temporary patients should be an important section of mental hospital population. Actually, quite the contrary has been the case. Of direct admissions to county and borough mental hospitals the *Twenty-second Report of the Board of Control* (for 1935) gives a percentage of 5·2 for temporary patients, though the percentage of direct admissions to private institutions and to single care is said to be 8·6. For the London County mental hospitals for the same year the percentage of temporary direct admissions to the total was only 4·1. Actually, on October 16 last there were, in the ten London county mental hospitals, 33 temporary patients (13 of them at St. Ebba's Hospital) out of a total population on the register of more than 22,000. A relatively high death-rate among temporary patients helps to keep the numbers low.

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

To be eligible for treatment as a temporary patient a sufferer from mental illness must be likely to benefit by such treatment, but for the time being must be "incapable of expressing himself as willing or unwilling to receive such treatment". Such a person may be admitted for treatment on a written application made by a husband or wife or relative or at the request of a husband or wife or relative by an authorized officer of the local authority. The application must be supported by a written recommendation signed by two registered medical practitioners, one of whom must be approved for the purpose by the Board of Control, while the other should, if possible, be the patient's usual medical attendant. In this procedure is to be found one of the reasons why, in London hospitals at least, temporary patients have not been greatly in evidence. It has appeared in practice that there is among a great number of the less enlightened of London's population extreme reluctance on the part of husbands, for example, to "sign away" their wives, as they put it. If mental hospital care is necessary the husband will reluctantly acquiesce; but if it is put to him that he should himself take an active step in the matter and sign a formal written application for his wife's admission to mental hospital care he will refuse point blank, even in the face of urgent and tactful explanation and persuasion. The reason doubtless lies in ignorance and prejudice, and is a relic of the old horror of the "asylum", which one hopes is dying, but certainly is by no means yet dead. Ignorance and prejudice die extremely hard, and it will take a long time to educate the average East End Londoner, let us say, to take an enlightened view of what is really his duty to a wife stuporose and confused after childbirth.

I have referred to the hypothetical case of husband and wife, because it is in such cases in the main that I believe the real usefulness of the statutory provisions for temporary treatment is to be found. I do not believe, with the greatest respect to the contrary opinion which the Board of Control have urged consistently, that in other directions temporary treatment ought to have a great future, and that the number of temporary patients in mental hospitals ought substantially to increase. Apart altogether from practical difficulty in getting responsible relatives to do what the Act requires of them, there is a much larger difficulty in making the provisions for temporary treatment work —I mean, the difficulty of deciding for whom temporary treatment really is proper. The patient must be (i) likely to benefit, and (ii) for the time being incapable of expressing himself as willing or unwilling to receive treatment. The first condition clearly rules out persons suffering from probably irrecoverable conditions, however non-volitional their state. The second condition rules out all those who refuse the offer of treatment, grossly irrational though the refusal may be. It is only sheer incapacity to express any wish, one way or the other, which counts. The Board of Control, in a memorandum on the subject which they issued early in 1935, suggested that if a patient were so confused or incoherent that at one moment he refused to receive treatment

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

and at the next expressed willingness, this might indicate such a complete lack of *continuity* of purpose that the patient might be considered non-volitional. I think this is sailing as near to the statutory breeze as is possible without being taken aback, and though I do not suggest that the Board's standard, properly applied, would necessarily be too easy, I am not at all sure that some of the temporary patients who have been admitted for treatment at some hospitals—though not, I think, the public hospitals of London—have not actually had an ascertainable will to be treated, or at any rate have not been capable of expressing such a will, with proper prompting. But there is no doubt that in true confusional states temporary treatment would be proper within the strictest interpretation of the statute, and in such cases the ability of an intelligent husband to secure proper treatment for his wife while avoiding the stigma of certification needs only to be mentioned to be appreciated.

On the other hand, I do not think that treatment as a *temporary* patient would generally be proper for the senile old man or old woman who at home is too tiresome and difficult to be tolerated, and in the open ward of a general infirmary is often, and especially at night, a nuisance to other patients, feeble and perhaps physically ill, but who, once admitted to the discipline and ordered regime of an institution where such cases are understood and treated together, reacts with astonishing facility and is much quieter and more contented. Such patients in the past have been collected in workhouse infirmaries, or certified and sent to the county mental hospital. The latter course is unfortunate; no girl, for example, likes to have to admit to a young man that "Granny died in the asylum"; besides, the mental hospital accommodation is capable of use for other cases for which it is even more urgently needed. The workhouse infirmary may not be a very happy abode for the last few months of declining age—some workhouse infirmaries which I have seen have been complete pictures of forbidding dullness. Here, in London, a happy middle course has been devised. One of the institutions built by the former Metropolitan Asylums Board in its capacity as a central Poor Law authority for London was a large infirmary at Tooting Bec, which was—and still is, after its transfer to the London County Council's management—technically a "workhouse", but is now placed under the management of the Council's Mental Hospitals Committee and is reserved for cases of senile dementia, of both sexes. It receives patients who are certified under Section 24 of the Lunacy Act, 1890, for continuous care in a workhouse, or under Section 25 of the same Act are transferred from acute mental hospitals as suitable for workhouse care, but it also receives, under a purely administrative arrangement, old people whose mental decay has not been apparent till after the seventieth birthday, who have not been under detention for mental disorder at any earlier period of their lives, and for whom no formal certification or detention order is deemed necessary now. The result of this arrangement is that of considerably more than 2,000 patients housed at Tooting Bec Hospital, more than half are more

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

than 70 years old, have never been certified, and will die without certification. The hospital is specially built for its purpose as a large infirmary, it has none of the disadvantages of old workhouse accommodation adapted to serve a special purpose for which it was not designed, and it is popular with relatives who are assiduous in their visitation of these old patients, and appreciate the advantage of an institution actually in London and readily accessible. It is invaluable as a means of relief alike to the infirm wards of the London County mental hospital and to the infirmaries and observation wards of the Council's public health hospital service. Indeed, in the latter respect the relief is represented to be insufficient, and plans are in hand for the establishment as soon as possible of further accommodation, ancillary to Tooting Bec hospital, of the same type, but on another site.

It might be of interest here if I quote an analysis, recently published in the *Journal of Mental Science* by Dr. Pentreath and Dr. Dax, of cases—two groups, one of 638 and the other of 518—which passed through a London observation unit, each group under the scrutiny of a different medical officer attached to the unit (one of them seconded from the mental hospital service). Of these two groups a total of 13 individuals were, after full consideration, regarded as suitable for treatment as temporary patients and were sent as such to mental hospitals. The two groups were dealt with on different lines to test entirely different experimental ideas. In the smaller group of 518 cases an attempt was made to send every strictly non-volitional case away as a temporary patient, provided there was a good chance of ultimate recovery, but no expectation of recovery of volition for some weeks. Only 11 such cases were found. Of those 2 were still temporary patients when the analysis was prepared, 6 recovered (after periods of mental hospital treatment varying between one month and eleven), 2 were made voluntary patients, and the last was certified for compulsory detention. Of the larger group of 638 cases only 2 were sent away as temporary patients. It seemed that 23 others *might* have been dealt with as temporary patients within the first week of admission to the observation unit ; but they were kept in the unit for further observation. It is interesting to note what happened to them : 10 were sent home fully recovered within two to six weeks, 10 gained sufficient volition to be sent to mental hospitals as voluntary patients, 2 were made the subject of reception orders, and 1 died from sudden heart failure. Other confusional and non-volitional cases were numerous, but they were all quite unsuitable to be treated as temporary patients, because of a bad previous history, or the presence of progressive or irrecoverable organic disease, including the pre-senile degenerations : these were certified.

The conclusion drawn by the authors of the analysis is, first, that an extraordinarily small number of patients really are fit for temporary treatment at any time if the definition of the Act is adhered to strictly and, second, that after two or three weeks of treatment in a good observation unit the percentage

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

of cases for which the temporary treatment provisions, strictly applied, can be used is negligible; but since the patients concerned either recover or go away as voluntary patients this is not a matter of great moment.

This conclusion is interesting as bearing out views which the London County Council has held for some time. The Board of Control have given it as their opinion that at least 10% of patients admitted to public mental hospitals might have been dealt with as temporary patients. But during 7½ months, from February to October, 1935, 1,686 patients were admitted to London county mental hospitals under summary reception orders. Of those, 8 only, representing ·47% of the total number of reception order admissions, had been notified by medical superintendents (who had been asked to keep special observation on the point) as cases which in their opinion *at the time of admission* might have been dealt with as temporary patients. And even that already negligible quantity was found to be further reduced by the existence in six of the eight cases of definite evidence, found on inquiry, that the patients were volitional *at the time of certification*.

It is necessary now to turn to consideration of the other class of admission, the *voluntary patient*, which, for the first time, the Mental Treatment Act made possible for county and borough mental hospitals. As I said earlier, the reception of voluntary patients is not in so many words made an obligatory duty for local authorities, but they are given power in terms which it would be difficult for any local authority wholly to disregard.

Any person may be received as a voluntary patient "who is desirous of submitting himself to treatment for mental illness, and who makes a written application for the purpose to the person in charge" of any mental hospital maintained by a local authority, of any registered hospital or licensed house or of any hospital, nursing home or place specially approved for such reception and treatment by the Board of Control, or the patient may be received voluntarily as a single patient into the charge of any person so approved. A person less than 16 years old may be received as a voluntary patient on written application by the parent or guardian supported by a medical recommendation, but a voluntary patient less than 16 years old may not be received on his own application. The reception of a voluntary patient is not associated with any form of reception order or "certificate", it is entirely informal save for such formalities as the receiving authority may find it necessary to impose for the purpose of securing payment of maintenance, and the voluntary patient may leave the place of treatment if he (or his parent or guardian, if he is less than 16 years old) gives seventy-two hours' notice in writing of his desire to do so. On the other hand, if the voluntary patient at any time becomes incapable of expressing himself as willing or unwilling to continue to receive treatment (in other words, becomes a fit subject for treatment as a temporary patient), he may not thereafter remain as a voluntary patient for more than twenty-eight days, during which time he should be discharged, unless steps

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

have been taken to get him further treatment as a temporary patient or he has again become capable of expressing himself, and either desires to remain for further voluntary treatment or to withdraw, or is so irrational that steps to secure a reception order for compulsory treatment have to be taken.

Now here is a provision definitely new and definitely and progressively beneficial. I say "new", because although under the Lunacy Act, 1890, it was possible for the manager of a licensed house, with special consent, to receive a boarder without certificate for a limited time, and even to receive and lodge as a boarder a relative or friend of a patient, and the reception of a boarder in a registered hospital also was recognized, this provision could not be applied to a publicly managed mental hospital. A successful, if limited, attempt to get over this difficulty was made when the Maudsley Hospital was first provided, to deal with recent and recoverable cases. The hospital, as one of the London County Council's mental hospitals, could only rank nominally with the rest, though it was meant to serve a more highly specialized purpose than the others and it was recognized that the statutory restriction of its population to patients capable of being certified would defeat the object it was intended to fulfil. By means, therefore, of a private Act, in 1915, the London County Council obtained what were then unique powers to receive in this particular unit of its mental hospital service persons who desired to submit themselves voluntarily, without certificate or reception order. Later it was decided, as a matter of domestic policy, to restrict the resident population of the Maudsley Hospital to voluntary patients, and from the outset therefore the Hospital has never treated anyone save on a voluntary basis. It was agreed that every patient before admission should be required to sign a form of application on which he was informed of his right to leave the Hospital within twenty-four hours of giving notice of desire to do so, and this is still the practice, notwithstanding the power which the Mental Treatment Act now gives to detain a voluntary patient if necessary for seventy-two hours after notice. Moreover it is a rule of the Hospital that, in order to preserve the voluntary basis of its treatment from any possibility of challenge, no patient shall be certified in the Hospital, either for retention there or for transfer to any other mental hospital for further involuntary treatment. But not until 1931 could any early, uncertifiable case of mental disturbance be submitted for reception and treatment in an ordinary county or borough mental hospital.

It is to be observed that the only definition of a voluntary patient which the Mental Treatment Act provides is the requirement that the patient must desire "treatment for mental illness". There must, therefore, be some apparent disorder of conduct, however slight, or some exaggerated fear or dread, or some self-appreciated tendency which is abnormal, sufficient to warrant the use of the word "illness". It is necessary to frown sternly on the person who is likely to find in the comforts and care of a mental hospital a congenial refuge from a cold world, in which effort is called for which such a

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

social mollusc is indisposed to make if maintenance can be had for the asking. Persons of that type are not so rare as might be supposed ; for them the mental hospital is infinitely to be preferred to the bleaker atmosphere of public assistance. And there is, of course, to go a step further, the deliberate malingerer, of a type illustrated by a gentleman who not long since (but before voluntary treatment was a possibility) made himself a considerable nuisance in mental hospitals in more than one part of the country. He followed normally a career of petty crime, but when he had reason to believe that the police were getting undesirably curious about him he withdrew himself to the nearest casual ward, gave an assumed name, acted with some skill the not very difficult part of a gloomy melancholic, refusing to speak and to eat, and promptly found his way to the local asylum, where he very soon began to expand and to shed his depression, until inconvenient inquiries were made, when depression invariably recurred. Unfortunately for London, and perhaps for him, he had a London settlement, which more than once brought him back to a London mental hospital, in which he was well known and from which, in spite of his efforts to remain, he was always firmly ejected. His is an instance, and not too extreme an instance, of a danger which the offer of voluntary treatment may invite.

At the same time if voluntary treatment is to do what is expected of it, it must be applied early, and the earlier the better. The trouble hitherto in mental hospitals in this country has been that they have not been available in most cases until too late for the best kind of result. The commonplace that "prevention is better than cure" in respect of mental illness need not, I am sure, be laboured before an audience such as this. For instance, it is pretty well recognized nowadays that in malarial treatment lies the great hope for the general paralytic ; but if treatment is delayed until the patient exhibits the classic symptoms of the well-developed disease, there is the likelihood that permanent damage has been done and the risk that treatment, after all, will succeed only in prolonging the useless life of a permanent dement. On the other hand, if serological findings indicate that a condition exists which has not yet produced actual disturbance of conduct, though there is a practical certainty that, if untreated, such disturbances will develop, there is very good ground for giving the widest benefit of any doubt there may be to the patient who has plenty of intelligent insight and is readily persuaded of his danger, and to ask for admission to a mental hospital where an efficient centre for treatment has been established. I shall have more to say later about this particular point ; meantime the instance I quote may serve to illustrate the need, sometimes, for a generous interpretation of what is mental illness.

I take it that no one here would support the attitude adopted by the medical superintendent of one hospital, who shall be nameless. What he is reported to have said is something like this: "I don't like this idea of voluntary treatment. Voluntary patients are a nuisance—they interfere with the normal

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

routine, they are touchy and difficult, they can't be controlled like the certified patient, and they are constantly in and out of the place. But in point of fact I am not much troubled with them. I believe in perfect frankness at the outset; it is only fair to the prospective patient. When a man comes to me and offers himself as a voluntary patient, I always say: 'Now, there is one thing you ought to understand: this place to which you are coming is what used to be called the county lunatic asylum. You quite appreciate that, don't you? If not, would you like to think about your request?' . . . And I find that nearly always that is the last I hear about him. . . . Honesty really *is* the best policy, don't you think?"

The Board of Control have had a good deal to say, very properly, about voluntary treatment in their reports from time to time, and two years ago, in their report for 1934, they commented on what they regarded as an abuse of the statute in the admission to mental hospitals for treatment as voluntary patients of relatively low-grade mentally defective children on the application of the parent or guardian. It is difficult to appreciate how such a case could be regarded as "likely to be benefited by being received . . . for treatment for mental illness", and certainly a general extension of such a practice should be deprecated. But there is another class of voluntary patient which has contributed fairly largely to the total numbers of such patients under care, viz., the chronic institutionalized case of some years' standing in the mental hospital, already granted a substantial degree of personal freedom on parole, but not fit to go completely to the outside world without care and control, which could not be provided. To allow such patients, who obviously are still mentally ill and are not deemed recoverable, to ask for continued treatment on a voluntary basis, because they are likely to benefit thereby, is surely quite legitimate. Voluntary status is definitely to the patients' benefit, it enhances their self-respect and adds to their comfort. Nevertheless, these are not the kind of early and hopefully recoverable case which the legislature manifestly had principally in mind when the provisions for voluntary treatment were devised.

The number of voluntary patients under treatment has grown, is growing and should grow further. During 1935 the Board of Control shows that of 24,166 direct admissions to county and borough mental hospitals, 5,834 (or 24·1%) were voluntary, as against 1,258 (or 5·2%) temporary and 17,074 (or 70 7%) certified. For the year 1933 the corresponding percentages on a total of 22,493 direct admissions were 13·2% voluntary, 1·5% temporary and 85·3% certified, so that the proportion of certified admissions relative to the total appears to be lessening as the proportion of voluntary admissions increases. For the London County mental hospitals (excluding the Maudsley Hospital, where all the patients are voluntary) the percentages of voluntary and certified admissions during 1935 to the total of 3,356 was respectively 18·6 voluntary and 78 certified.

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

Now it is not of much use (as the anecdote which I repeated a few moments ago helps to prove) to offer voluntary treatment in forbidding surroundings or in accommodation where there is imperfect classification, and where the susceptible voluntary patient would be in close association with acutely disturbed and disturbing cases. Here, in the Maudsley Hospital, the whole accommodation is designed, after some modification of the original experimental layout, to serve voluntary patients. But even in the oldest hospitals, which have vast accumulations of chronic cases and a large element of the turbulent class, it has been found that the addition of carefully planned detached admission hospital and convalescent villas provides quite well for the needs of early voluntary cases, especially when the admission hospitals are in the charge throughout of suitable women nurses, so as to secure completely the hospital atmosphere on the male side. In the London service we are now trying out an experiment which promises to be a striking success. The Maudsley Hospital, as has been explained, is reserved entirely for voluntary patients, and moreover, in the main, for those who offer a prospect of early cure and discharge, subject always to the need for the retention of some cases of special interest from the point of view of research or teaching. But speaking generally the specialized accommodation is so valuable and is in such acute demand that effort is made to open it to the aid of as many new cases as possible, and there is an average turnover of perhaps four patients to each bed annually. Nevertheless there are many patients with a perfectly good prognosis for whom far longer than three months' treatment is certain to be necessary. The accommodation, therefore, at St. Ebba's Hospital, at Epsom, which was originally designed as a colony for insane epileptics, in an attractive series of one-storied villas, is being added to so as to double its original capacity ; a specially designed admission hospital, a sick hospital and a convalescent villa already have been added, and the whole hospital will presently be available to serve the needs of voluntary and, if necessary, temporary patients, as well as patients under certificate who have a hopeful prognosis, but are likely to need somewhat prolonged treatment. The arrangement of the hospital in detached villas makes it specially suitable for patients whose treatment calls for a good deal of classified segregation. Generally speaking, the difference between St. Ebba's and the Maudsley lies in the fact (1) that the Maudsley is wholly for voluntary patients, while St. Ebba's is not, and (2) that at the Maudsley most of the voluntary patients are uncertified *and uncertifiable*, while at St. Ebba's many of the uncertified are *certifiable*, though, with their co-operation, certification is not necessary. As between St. Ebba's and the other London County mental hospitals, there is the distinction that at St. Ebba's there is to be no accumulation of chronic debris. The specialized accommodation will be too valuable to permit of that, and the patient who does not progress after a sufficient time of active treatment toward recovery and discharge should be removed to a hospital with ample accommodation for the irrecoverable chonic.

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

All this opens up a wide vista of opportunity for debate as to the disadvantage to certain mental hospitals of a measure of classification which may tend to concentrate in them the irrecoverable at the expense of other hospitals to which the recoverable are more and more encouraged to resort for treatment. Actually in a large service such as London has established, with ten county mental hospitals, to say nothing of four certified institutions for defectives and five nondescript hospitals which have a Poor Law status and, to some extent, serve a double purpose in relief of the mental hospitals proper and in the colony care of the mentally defective, in such a service, I say, it is impossible to avoid a large measure of specialization of function. The same sort of thing which on a small scale is done in every mental hospital in the classification of its admission units, its convalescent units, its infirmary wards and its wards for turbulent and disturbing patients, must, to a certain extent, be done on a larger scale as between hospital and hospital when many institutions serve under one general direction. In face of inexorable need it is vain to plead, as I have heard it pleaded, that to specialize treatment, as opposed to custodial care, in a few hospitals is to brand the others with the age-long stigma of the asylum, to perpetuate the public distaste for them, and to doom the medical and nursing staff employed in them to the depressing task of thankless carefulness without the cheering prospect of a recovery-rate. Actually, of course, even with the degree of specialization which obtains in London, none of its mental hospitals is without recoverable patients or without voluntary patients, and though the highly specialized function of the Maudsley Hospital and St. Ebba's Hospital may concentrate a certain perhaps enviable limelight upon those institutions, no other hospital is denied the opportunity to do more than merely warehouse broken humanity. So much in that matter depends on enlightened medical direction, such as I gladly acknowledge exists throughout the London service, and on the alert and industrious co-operation of a staff of medical assistants. The opportunity for such industry is endless and varied.

Speaking as I did just now of St. Ebba's Hospital reminds me to say a word or two about an experiment which is being tried there in vocational re-education, under powers bestowed by the Mental Treatment Act, 1930, upon local authorities to provide "after-care" for persons who have undergone treatment for mental illness—powers which, incidentally, are available for recovered voluntary or certified or temporary patients. You must all appreciate the problem which is presented when a patient whose mental breakdown has been largely his reaction to an unsuitable environment is ready for discharge, and has no prospect before him but return to the old, detestable round. Whether the patient has been under order or has received treatment voluntarily, the problem on discharge is the same: if he goes back to the unsatisfactory home surroundings or to the uncongenial employment mental disturbance is likely —even probable—to recur. Unfavourable home conditions can be explored

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

by the social worker, who nowadays ought to be attached to the staff of every mental hospital, and an effort can be made, while the patient himself is gaining insight and self-reliance, to educate his wife, perhaps, or the other relatives with whom he has been at cross-purposes, to a better appreciation of his troubles so that he may have a different *milieu* to which to return. But that procedure cannot solve the difficulties of a man condemned to earn his bread and butter by following some industrial groove which his soul has come to loathe, the further prospect of which may be torment to him, or at any rate a black cloud on his mental horizon. What we are trying to do, so far on a small scale, but with really hopeful prospects, at St. Ebba's Hospital is to take advantage of the London County Council's system of technical education in trade centres and polytechnics, to provide leave of absence (with maintenance if necessary) to enable a suitable patient to train himself for a new and more congenial job, and to get him placement in due course in such a job. There are some highly organized trades which are closed to the late-comer, but there are still some to which that restriction does not apply, and it has proved to be of enormous advantage to a small clerk with no prospects and with his former job lost to him, even if he had the heart to return to it, that he should be able to develop a discovered taste for handicraft as a motor mechanic or in leather work and to fit himself thus for a new means of livelihood. It may well be that London is more favourably situated than some other centres for work of this kind, but the possibility of development on such lines as these should not be overlooked.

There is, moreover, a further possibility, which may be emphasized by the advent of the voluntary patient—who may sometimes be a person with a rather higher level of culture than some of the certified—the possibility of introducing to a mental hospital the idea of a study-circle. I have no time to discuss it at length, and I fully appreciate a number of real difficulties which are involved —difficulties arising at the outset from the need to find someone from beyond the hospital with knowledge and discretion enough to enable him to come in and inaugurate fruitful reading and discussion on simple and helpful lines— difficulties likely to be amplified if there is conscious effort to talk down to the patients who are thought fit to share in the common effort at improvement and, even more, if the volunteer leader should develop and air original ideas as to the fitness of his students for discharge which are not shared by the medical superintendent. Still, I wonder if the breath of outer air thus introduced in the right way by the right person might not be worth breathing.

Now I think the time has come for me to attempt a reference to a subject which is fundamental to the whole question of mental treatment—I mean the method by which the patient finds his way to the mental hospital. The advent of the voluntary patient has made this important. Before 1931 county and borough mental hospitals were concerned only with the care of

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

mental patients received under order, and the processes by which orders were procured were (as they still are for the certified case) matter for the Poor Law authority, the relieving officer and the justice, and only indirectly of concern for the mental hospital authority. What arrangements, if any, were made for temporary care during observation prior to certification were no responsibility of the medical superintendent of the mental hospital to which the patient ultimately came for reception. The voluntary patient, on the other hand, though he may be introduced through Poor Law agency, has to make personal application for admission to the medical superintendent who he hopes will receive him, and therefore so far as this type of patient, and the temporary patient also, is concerned, the case is now altered.

In London the regular portal of approach to the mental hospital for all rate-aided patients, i.e., for the vast majority of those admitted under reception order and for a great many voluntary patients also, is the observation ward. Before the Local Government Act, 1929, transferred to county and borough councils the functions of the former Poor Law guardians, each board of guardians had its own observation ward, such as it was—a poor thing enough in many cases—and to this unit, attached to the workhouse infirmary, it was the invariable practice of relieving officers to admit every person presumed to need mental hospital care, on a three-day order under Section 20 of the Lunacy Act, 1890, which might at need be extended by a justice for a further fourteen days. At law there was no absolute necessity for admission to an observation ward before admission to a mental hospital; the proposed patient might have been seen by a justice in his own home and removed thence to hospital, an order having been made, but in practice the arrangement was convenient, and indeed the only one practicable in nearly every case, when one remembers (1) the condition of many of the homes and the imperative need for immediate care, (2) the convenience of the justice, and (3) the impossibility of a justice, or the relieving officer who was advising him, knowing without inquiry and corresponding delay in which of the mental hospitals a bed could be secured. These practical considerations still obtain in London, though conditions may not be the same in country districts. There is the further advantage that in some cases of transient mental disturbance a period of preliminary observation in a suitable unit may avoid completely the need for certification and removal to a mental hospital, which may be no bad thing for the patient. It used, I can very well remember, to be a constant complaint of some mental hospital superintendents that they received, under order, alcoholics who doubtless had been mentally deranged when seen by a justice and ordered to be sent for mental hospital care but who, on reception, could no longer be said to be insane and had thus been subjected to unnecessary hardship. A recent examination of rather more than 500 of the admissions to one of the larger London observation units showed that nearly 10% were alcoholics (omitting cases admitted in a state of intoxication secondary to a psychosis,

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

who were certified, and a few old men brought in after celebrations who later were discharged), and of this 10% not quite a fourth were certified or sent for mental hospital care as voluntary patients.

But the Board of Control have had some very hard things to say about observation wards, particularly in their last Annual Report, for 1935, in which they criticize the small, ill-equipped wards still be to found in some places, without facilities for classification and without trained staff. Such criticism could hardly be challenged, and it might at one time have been levelled at London, though the effort which is being made by the Council's Public Health Department to centralize observation wards in larger and well-equipped units should soon take all sting from it, if indeed the sting has not already been drawn. I do not think, when you see, as you are presently to do, the observation unit attached to St. Francis's Hospital and the work done in it, that you will feel that severely adverse criticism would be justified. But the Board go further in their report, and urge that the observation ward, even at its best, is not good—that it is an unnecessary piece of machinery, even for the benefit of the mental patient whose condition is difficult to diagnose or whose mental disturbance clears up within a few days. Such a patient, they suggest, could be hastened to the mental hospital, either as a voluntary patient or, if confused, as a temporary patient or, if refusing treatment and still a case for doubt, on an urgency order which would enable certification to be postponed until the need for it is beyond question. Incidentally, I believe that the very acute case, for which the urgency order would most probably be suitable, is just the kind of case that would most quickly recover in an observation ward. But the Board do not allow for the fact that in such a case, if dealt with on an urgency order, though the patient may escape the stigma of actual "certification", he cannot escape the fact of having been an inmate of a mental hospital, and though one hopes that one day society will be enlightened enough to regard that fact as free from stigma, the world moves slowly and that day has not yet dawned, and seems unlikely soon to do so. The Board even go so far as to suggest that the betterment of observation wards is to be deprecated, because money is spent thus which would better be spent on the improvement of a mental hospital, and there is a "temptation to undertake active treatment" in the observation ward—a practice inconsistent with the observation ward's function merely of diagnosis.

Now I venture to think that in presenting this thesis the Board go too far, at least where London is concerned. Devoutly as one may hope for the time when the mental hospital will figure in the public mind as a place of treatment as little to be dreaded, indeed as much to be welcomed as, say, the fever hospital, one is bound to face facts, and the facts are that, on a moderate estimate, ninety-nine people in a hundred regard a mental illness as a particularly terrible visitation, and one which leaves a lasting mark upon the sufferer. The increase of early treatment, with its briefer term and hopeful ending,

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

growth of knowledge of new methods of treatment such as are used for general paralysis and schizophrenia, the possibility, even, of discovery of other methods of treatment of that kind, ought to help to dispel the clinging stigma, but while stigma remains it is surely unnecessary, for the sake of a rather barren principle, to condemn every sufferer to run the risk of it and to declare against the facts that it ought not to exist and therefore does not exist! Moreover in London, with a carefully regulated centralized system of allotting beds in ten hospitals, some of them containing specialized units which are not suitable for every case—a system which must be employed to prevent sheer chaos—it is, in fact, impossible to admit to mental hospitals directly from their homes more than an insignificant fraction of the hundreds of cases which call for immediate care. The observation ward is essential, and it ought therefore to be as good as it can be made, and if in it some cases which otherwise would go to a mental hospital can be allowed to find themselves, and to be returned to the world without entering the mental hospital—why not?

But there are certain features which a good observation unit must possess, apart from size and planning, and arrangements to make it possible to keep shrinking, impressionable, depressed cases from direct association with the coarser manifestations of excited, turbulent cases—the kind of association which, in the past, is known to have done harm which the mental hospital had later to assuage. In the first place, the observation unit ought to have staff adequately trained and in sufficient number. And in the second place it ought (and this is most important) to be in direct association with the mental hospital or hospitals which it is to serve, by means of liaison of medical staff. In London this liaison is secured in two ways: (1) by seconding experienced medical officers from the mental hospital service to take charge in succession, for limited terms, of the larger observation units, and also (2) by detailing senior medical officers of mental hospitals to act as visiting psychiatric consultants for each observation unit and for the municipal hospitals and Poor Law institutions which the unit serves. Thus a double benefit is secured, for the diagnostic function of the observation ward is greatly improved, and expert advice can be given whether patients in other hospitals ought to pass to the observation ward with a view to mental hospital treatment, while, on the other hand, the mental hospital officer gets a first-hand acquaintance with psychiatric cases at a stage earlier than that at which invariably, in the past, they reached him. Experience hitherto confined to end-results may now be tempered by acquaintance with earlier beginnings. I know that something of this sort is achieved with admirable results at smaller centres, where a close liaison between the mental hospital and neighbouring general hospitals can be secured by means of out-patient clinics, conducted at the latter by the staff of the former.

And this leads me to say something which I have not yet said on the subject of out-patient clinics. The Mental Treatment Act, 1930, not only created the

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

two new types of "voluntary" and "temporary" patient and made provision for their treatment in mental hospitals, but it empowered local authorities to provide means for the treatment as out-patients, gratuitously if necessary, of persons suffering from mental illness. This is a very important provision which has been developed in some quarters on the lines to which I have just briefly referred. It is of the utmost importance, if voluntary treatment is to mean anything vital and progressive, that the mental hospital should get its tentacles into the outside world. It must feel for its patients, for they will never come of their own accord unless easy contact is made. The problem in London is not so simple as it is, say, in Oxford or in Cardiff, where one mental hospital and one large general hospital are situated not too far apart and where means of liaison are obvious. Relations between the London County Council, with its own great system of municipal general hospitals as well as its mental hospital system, and the large voluntary general hospitals with teaching schools (twelve of which have neurological and psychiatric departments), are not so obvious, in addition to which it must not be forgotten that there are in London three neurological hospitals and three specialist psychiatric out-patient clinics. In fact, the medical superintendents of two of the London County mental hospitals hold honorary positions, each on the staff of one of the London voluntary hospitals, and one conducts a weekly psychiatric out-patient clinic at his voluntary hospital, but the presence in the Council's scheme of affairs of the Maudsley Hospital is a factor which must affect the Council's arrangements. Actually the Maudsley Hospital has a close and obvious liaison with King's College Hospital across the way, and the medical superintendent holds a position on the King's College staff; but apart from this there is, at the Maudsley Hospital, a large and active out-patient department with a clientele of between 3,000 and 3,500 patients a year and attendances numbering more than 19,000 annually, and in association with this, for the benefit of out-patients from areas north of the Thames, three clinics are conducted by members of the Maudsley Hospital staff. It remains to be seen whether, later, it may be necessary to establish, for the north of London, a more elaborate out-patient psychiatric clinic, perhaps with a few beds at its disposal for urgent cases, but in no sense a reduplication of the Maudsley Hospital itself; meantime all our experience goes to show that, for the special needs of London, concentration of out-patient treatment, rather than dispersal in a number of not completely co-ordinated centres, is the wise policy. Of the patients who attended at the Maudsley Out-Patient Department during 1935, 10% were admitted for in-patient treatment at the Maudsley Hospital itself, 42% were directed elsewhere for treatment, and 48% received continued out-patient treatment with three or more attendances.

An important addition to the staff of an out-patient department is a psychiatric social worker, for history-taking, follow-up work, etc. Indeed,

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

without such a functionary the department cannot do the work which it sets out to do.

I said something earlier in this address about the need for the early admission to a properly-managed clinic of cases of general paralysis, for malarial treatment, and I promised to say more. What I want to say is this, and it shall be the last point upon which I propose to touch. At Horton Hospital (which you are presently to visit) the Council has for the past twelve years conducted a centre where, with the immense advantage of close association with a laboratory established by the Ministry of Health for the study of malaria as a disease, it has been possible to develop and perfect the technique of malarial infection and nursing and cure, for the benefit of the general paralytic. As a result malarial treatment can now be administered at Horton with the least possible risk of untoward complication and the greatest possible prospect of favourable results, and the council has been forced, after careful investigation of results, to the conclusion that, in fairness to the patients who are to receive malarial treatment, that treatment shall in future be given only at Horton, though other forms of treatment, if they are desired in preference to malaria, can be administered elsewhere. But it begins to be apparent that if the best results are to be secured from malaria it ought to be applied not only in the developed stages of general paralysis, but in the earlier asymptomatic stages of cerebro-spinal syphilis. This need may make it difficult in some cases where a prophylactic infection by malaria is indicated to bring the patient within the scope even of the Mental Treatment Act as a voluntary patient seeking treatment for "mental illness" which is prospective only. It may be necessary to explore the possibility of an establishment, in close conjunction with the mental hospital, but not actually in a technical sense part of it, in which purely prophylactic treatment may be carried on with all the advantage of the expert nursing, laboratory service and medical direction which the mental hospital can afford. Obviously it cannot be hoped that the expensive duplication of the laboratory and other advantages at an entirely separate centre will furnish a practical alternative. Actually at present it is only too apparent that the application of malarial treatment at some centres has been unsatisfactory, just because of the lack of the experience which alone enables just determination of what to do and how far to go.

Only one other point arises. In the examination of the histories of general paralytics it is often apparent that a wife or husband must be infected with syphilis and that there are children who may be congenital syphilitics. The same sort of thing occurs, from another angle, when at an institution for defectives a congenital syphilitic is found whose mother is obviously of child-bearing age and, unless treated, may produce other congenitally defective offspring. An effort has been made in the London service, with varying success, to secure means of treatment for the infected relatives of patients. This is, of course, preventive medicine, and it calls for co-operation from

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press

agencies outside the mental hospital service itself. Experience has shown that the difficulty of getting co-operation is more often with the person who ought to have the treatment than with the agencies who are prepared to give it. The details are doubtless for discussion elsewhere, but I venture to bring the point to notice because it seems to me to open possibilities which might well be explored in many services beside the London service.

https://doi.org/10.1192/bjp.84.348.183 Published online by Cambridge University Press