Part IV.—Notes and News.

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION.

Quarterly Meeting.

The usual Quarterly Meeting of the Association was held at the Headquarters, No. 11, Chandos Street, Cavendish Square, London, on Tuesday, November 20, 1934, Dr. Daniel Rambaut, M.A., M.D., B.Ch., President, in the Chair.

Minutes.

The minutes of the previous meeting, which have already appeared in the Journal, were taken as read and approved.

Obituary.

The President said that the next item involved the performance of a painful duty, namely, to record the decease, since the last meeting, of certain members of the Association. These were: Dr. Eric Macnamara and Dr. Hugh Kerr, the latter of the Bucks Mental Hospital. He asked if Dr. Hamblin Smith would say a few words about Dr. Macnamara.

Dr. Hamblin Smith said he regarded it as a high privilege to have this opportunity of making a few remarks in commemoration of their deceased colleague. Probably there were members present who could speak with greater authority and in more detail as to Dr. Macnamara's medical work and of his professional distinction, but the speaker's own personal acquaintance with him extended back, probably, longer than that of anyone else among those at this meeting, for it dated from the time, forty-six years ago, when they were undergraduates at the same college at Cambridge. Dr. Macnamara was a year above him, and on the speaker going there he received from him a great deal of kindly help and assistance—a thing which freshmen did not always get from their seniors. Later they both rowed together in the same boat for more than one year, namely, in the college boat, some photographs of which were among his most cherished possessions. This gave him the opportunity of getting to know Dr. Macnamara very well, and he remembered many instances of his high generosity and character, and his detestation of all that was mean and petty. He was, indeed, a man to whom the old tag about saying nothing but good about the dead did not apply, because it was impossible for anyone to speak ill of him, and the news of his death came to the speaker—as it probably had to many of those present—with a sense of deep personal loss.

Dr. Good (Oxford), referring to the death of Dr. Kerr, said they were in the Services at the same time, and he knew him in the very early days of the Medico-Psychological Association, when they were in the habit of discussing what the future might be. He loved his patients, and there was no need to say more of him.

The President said he understood that since the last meeting one of the former Presidents, Dr. Leeper, had lost his wife, who was present with him at the last Annual Meeting, at Northampton.

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Members present stood in silence in their places for a short time in memory of the deceased, and agreed to letters of condolence being sent to the respective relatives.

Election of Candidates for Membership.

The following five candidates for election successfully sustained the ballot; the scrutineers were Dr. McRae and Dr. H. C. Beccle:

Beggs, John, M.B., Ch.B., B.A.O.T.C.D., Senior Assistant Physician, The Warneford, Oxford.
Proposed by Drs. Alex. W. Neill, R. Worth and H. C. Beccle.

Cates, Bernard, M.R.C.S., L.R.C.P., D.P.M.Lond., Temporary Junior Assistant Physician, Bethlem Royal Hospital; 11, Wentworth Road, Golders Green, N.W. 11.
Proposed by Drs. J. Porter Phillips, D. Robertson and C. Lovell.

Hill, Thomas Walter, M.D.Glasg., D.P.H.Camb., London University Certificate of Proficiency in Mental Deficiency, Deputy Medical Officer of Health and Certifying Officer under M.D. Acts, West Ham County Borough; 51a, Longridge Road, London, S.W. 5.
Proposed by Drs. J. Harvey Cuthbert, R. M. Macfarlane and G. Somerville.

Slight, David, M.B., Ch.B.Edin., D.P.M.Eng., McGill University, Montreal, Canada.
Proposed by Drs. E. Mapother, A. A. W. Petrie and J. B. S. Lewis.

Yates, Irene, M.D., B.S.Lond., M.R.C.P.Lond., D.P.M., Assistant Medical Officer, Dorset House, Clifton Down, Bristol 8.
Proposed by Drs. E. Casson, F. Margaret Grant and A. J. Lewis.

The President said he had now to bring forward the Report of the Council on the matter which arose at its meeting.

The Educational Committee reported that they had approved the draft Syllabus and Regulations for the Training and Examination of Candidates for the Certificate in Occupational Therapy. Their report was adopted by the Council.

British Medical Association Report.—A conference between representatives of the British Medical Association and this Association took place on October 5, when Paragraph 52 iii of the B.M.A. Report was discussed. The Royal Medico-Psychological Association took exception to this paragraph, and, after a long and friendly discussion, the British Medical Association consented to withdraw this paragraph and replace it by a new one in keeping with the Royal Medico-Psychological Association's suggestions. Paragraph 42 was also re-drafted, to render its meaning less obscure.

Alteration of Bye-laws.—The Privy Council have approved the alteration of the Bye-laws as proposed at the Annual Meeting, 1934.

Voluntary Sterilization.—A motion was carried at the Council Meeting preceding this General Meeting that the Parliamentary Committee do consider the question of the views and general principles of the Association in regard to sterilization.

Register of Live Nurses.—The question has again arisen regarding the keeping of a register of live nurses. It was agreed that the Mental Nursing Advisory Committee prepare a report on the matter.

Representation of the Association on the General Medical Council.—It was agreed that when the next vacancy occurs on the General Medical Council, a member of the Association should be nominated to represent the Association on that Council.

Maudsley Lecture, 1935.—Dr. L. C. Bruce, the Maudsley Lecturer for 1935, wishes to deliver his lecture in February instead of May. This request was agreed to.

Honorary Librarian's Gift.—Dr. Whitwell has presented, in addition to many

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other books of great historical interest and value, a fine copy, in the original binding, of *De Proprietatibus Rerum*, 1483, by Bartholomaeus Anglicus. The Association must congratulate itself on having such an erudite, hard-working and splendid Honorary Librarian. (Applause.)

The next Quarterly Meeting.—The next Quarterly Meeting will take place on February 28, 1935.

Discussion on Section 5 of the Mental Treatment Act.

Sir Hubert Bond, in opening the discussion, said this section of the Act, especially the part relating to facilities for medical treatment, would, in years to come, be looked upon as a charter of liberty in treatment. It could well be entitled "No certification, but promptness of treatment", and he urged those in whose hands lay the chance of doing something in furtherance of these two objects to avail themselves of it. The Section had 17 sub-sections, as well as rules relating to it. His special purpose was to consider why a much fuller use had been made of this facility for early treatment without certification in some places than in others, and what were the obstacles in the latter. The word "failure" was inapplicable to the experience of the new provision so far. He did not doubt that, so far as lay within the province of members, they would see to it that the Section did not fail; indeed at some mental hospitals it had been used practically to the maximum possible. In relation to treatment which might affect the liberty of the subject and to procedure arising out of that relationship, patients were divisible into three grades of status—the willing, the indifferent, the unwilling (the synonyms in the Mental Treatment Act being "voluntary, temporary, certified"). With but few exceptions, it was easy to decide into which grade any given case should be placed; but cases were encountered in which such grading was not easy, and as to which the 28 days' suspension provided in the 12th sub-section was taken advantage of. The number of such apparent border-line cases must depend to some extent on the mental outlook and attitude of the examiner, and these cases could not be held to justify the formation of a fourth grade. He regarded it as important to realize that the middle grade of those he had referred to, those for whom the Act had designated temporary treatment, were biologically much more distinct than the other grades. These were the temporary patients, those who for the time being were incapable of expressing their willingness or their unwillingness to receive such treatment. The Board of Control reckoned the proportion of these patients to all mental patients as 15%. In the light of clinical experience, and judging by figures available, the Board suggested 55% as the proportion attainable in the case of voluntary admissions to county and borough mental hospitals, leaving therefore 30% as the proportion who required to come in under order and certificate.

Of the admissions into registered hospitals and licensed houses, some 6·5% were received as temporary patients, whereas 1·8% was the corresponding proportion for the public mental hospitals. The comment had been made, not unfairly, that whereas important sections in the Mental Treatment Act were directed specially to giving rate-aided patients advantages which hitherto only private patients had enjoyed, there was still this glaring inequality. It was pointed out that the number of temporary patients admitted to the public mental hospitals had not reached 300 in a year. Had this inequality not existed they should have numbered 3,000. It was too true that in about a third of the county and the borough mental hospitals no use had been made of this Section during the year 1933—a disappointing fact. Yet a careful analysis of all available figures brought a measure of solace and encouragement.

When non-users had been eliminated, it was found that of the admissions to the county mental hospitals during 1933, 2% were temporary patients, and of those to the borough mental hospitals the percentage was 5·3. Sir Hubert suggested that the great lesson to be drawn from this contrast between the county and the

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borough percentages was the powerful and beneficent results which arose from a close touch between the mental hospital medical staff, the general practitioners, and the lay officials, supported by the mental hospital committee and magistrates. The importance of this close touch was emphasized in conversations which Sir Hubert had had with superintendents of the larger institutions.

None of them pretended that Section 5 was ideal; not even officials of the Board thought so. Their job was to make it work, and pointing out the difficulties he was sure the remarks would fall on sympathetic ears.

Dr. NORMAN MOULSON said: "We want to treat incipient mental disorder without the stigma of certification." This was the statement of the late Earl Russell, when he was piloting Clause 5 of the Mental Treatment Bill through the House of Lords. "We are anxious," he said, "that the poor person who has to go to an institution to be treated, should be able to be treated there in the early stages without certification, because he may recover in quite a short time".

It is not the purpose of this contribution to the discussion to criticize the structure of the Act. The Chairman of the Board of Control said at the 1933 Mental Health Conference, "Most of us could devise Bills which we should find much more satisfactory than the Mental Treatment Act, but they would suffer from one really fatal flaw—they would not, in the present stage of public opinion, have any chance of being passed".

The Minister of Health at the same Conference stated, "Section 5 of the Act institutes an experiment on which may depend the chances of securing at some future date Parliamentary assent to any extension of facilities for mental treatment without certification".

At present the only reasonable attitude is to take the Act as it stands, and to endeavour to carry out its provisions, not only in the spirit in which they are intended for the benefit of certain classes of patients, but with every rigorous safeguard our legislators have seen fit to impose, without which the Bill would never have been passed.

At Cefn Coed Hospital we have steadily tried to carry out the provisions of the Act, and I believe that the comparative success which has been attained is largely due to the fact that we have a new hospital, able to make its own routine and its own traditions. The Medical Superintendent quickly gained the confidence of the local general practitioners, who, almost without exception, have co-operated wholeheartedly. The painstaking care of the relieving officers has been admirable, and without it the scheme could not have succeeded. Widespread public interest, reflected in the sympathetic attitude of the local newspapers, has given us every chance. An important aid has been the close co-operation of other departments of the Public Health Service, the fever hospital, the maternity hospital, the public assistance hospital and the general hospitals, all of whom have called on us to help them with cases in which they had difficulty. Most of all the success is due to the personal endeavours of the Medical Superintendent; no less than 68% of the temporary patients received have in the first instance been seen by the Medical Superintendent, this figure including four cases seen by myself.

Mr. Cox, of the Metropolitan Relieving Officers' Association, stated last year that he believed the only type of case that could conveniently be dealt with under this section was the case of puerperal mania. This I believe to be an understatement. Since our opening we have received as temporary patients cases belonging to the following fourteen categories, and every one of these cases has been strictly suitable for admission within the meaning of Section 5.

(1) Confusion associated with epilepsy.
(2) Confusion from undiagnosed general paralysis.
(3) Acute mania.
(4) Depressive stupor.
(5) Confusion following alcoholism.
(6) Confusion following childbirth.
(7) Dementia præcox in a state of stupor.

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(8) Confusion from senility.
(9) Acute excitement in a congenital mental defective.
(10) Confusion with severe arteriosclerosis.
(11) Pneumonia with delirium.
(12) Catatonic excitement.
(13) Pellagra.
(14) Severe chorea.

In our first twelve months we received 31 temporary patients; the second twelve months is not yet completed, but we have taken in so far a further 23 such patients. The temporary patients have formed 10·28% of the total direct admissions. The female patients have been more numerous, forming 61% of the total. 26% of the total have been private patients.

In 37% of the temporary patients the co-operation of the relieving officers has been sought. Of these cases 60% were admitted in the daytime, whereas, of the cases in which the relieving officer was not consulted, 78% were brought in at night. Stated in other words, in 80% of the cases of night emergency they managed as best they could without a relieving officer. Of the cases brought in by the relieving officers under urgency certificate, which formed 5·71% of the total direct admissions, 66% came in by day. It would appear that in relation to temporary patients the chief function of the relieving officer is to pay for the taxi or ambulance! I believe that of the 30 cases in which urgency orders were used, some 43% might have been dealt with as temporary patients. 83·3% *of the temporary cases came directly from their own homes*; 12·9% came from other special or general hospitals, and *only* 3·7% *came from the public assistance hospitals*.

There is little to be said as to the actual recommendations. I think that the difficulty found by some practitioners in satisfactorily completing the statutory form of recommendation is due, in great part, to the way in which it has been drafted, so that it is confused with the ordinary medical certificate for a person of unsound mind. Speaking generally, I think one may say that the presence of definite unshakable delusions is an indication that the patient will not be suitable for treatment under Section 5. Three such cases very soon had to be certified.

For the recommendation to be valid one must be able to state that the patient—

(1) Is suffering from mental illness.
(2) Is likely to benefit by temporary treatment.
(3) Is, for the time being, incapable of expressing him- or herself as willing or unwilling to receive such treatment.

The first is self-evident. It seems superfluous, but there it is. The second that the patient is likely to benefit by temporary treatment, seems to me merely foolish. No one can reasonably blame the doctor for thinking that his patient is likely to benefit by temporary treatment. But the third, that the patient is, for the time being (whatever that may mean!), incapable of expressing him- or herself as willing or unwilling to receive such treatment—that is decisive, and is a condition which must be satisfied for the recommendation to be valid. "The patient is incapable of saying 'Yes, I should like to go for treatment'"—I am quoting the Earl of Onslow—"and is equally incapable of saying 'No'".

I should like to see this third section printed in heavier type, so that the practitioner could not fail to realize its pre-eminent importance. It is frequently missed altogether. One doctor even struck his pen through the section, and hoped that his recommendation would still be valid. I should like to see the question put to a prospective temporary patient, "Are you willing to go to hospital to receive treatment?", and I should like to see the patient's answer written down word for word. If he says "Yes" or "No", or what is equivalent to either of these, he cannot be made a temporary patient. If he fails to reply, or his reply is not to the point, his temporary treatment is permissible. But in any case the reply should be written down verbatim. I think the question might be printed on the present temporary form without making the form legally invalid.

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In a case involving the relieving officer, before the temporary form is correctly completed, the name of the patient must be written down in full no less than nine times. I suggest that a judicious sprinkling with the printed words " above-named patient " might obviate this form of annoyance. A number of doctors forget to state whether they are or are not the patient's usual medical attendant, which again results in correspondence. I believe this mistake, too, could be avoided by the use of heavier print for the three words, " am, am not ".

Sub-section 9 of the temporary provisions of the Act provides that the patient must be visited within one month of his reception by two members of the visiting committee. So far as it applies to a rate-aided hospital, I do not believe that this so-called safeguard is of any real value ; this is only my private opinion, but I think it will be confirmed. I suppose this provision was made as an attempt to satisfy a lurking desire of the lawyers to protect the liberty of the subject. If it really had this effect, one would not mind, *but one soon realizes that the patient's real protection is not so much a piece of paper, as the care and attention of his hospital doctor*.

Fifty-one per cent. of the first year's temporary patients were treated to conclusion without ever being certified. These include 18% who died in course of their treatment ; in the remaining 49% it was eventually necessary to resort to certification.

There may appear to be a great deal of work for a very moderate result, but I am sure that if any one of the 51% of patients who thus escaped certification had been closely related to any member of this Association, that member would feel that the labour had not been in vain.

It is obvious that Section 5 allows a patient who is acutely ill to obtain earlier hospital care ; for there is no longer any necessity to find a relieving officer and judicial authority. In a case of acute illness, a saving of a couple of hours may make the difference between life and death, as, for example, in a confused case of general paralysis, with a distended bladder.

I suppose that all will agree that a patient's status should make no difference to his medical treatment, and that he should be treated in the ward most appropriate to his condition ; no attempt to segregate temporary patients as such should be made.

All with experience will agree that the provisions of the Act impose a great deal of work upon the medical staff, and that, frankly, this work cannot be properly carried out with the customary large number of patients to each medical officer.

Practical points regarding the administration of the Act, so far as it relates to the patients who regain or lose volition, can only be learned by experience. Incidentally, they cause quite a lot of work for the clerk and steward.

The patient's progress depends entirely upon medical factors, but his status may show a complicated series of changes, as may be seen from a table which I have with me, showing the course and ultimate lot of our first 38 temporary patients.

	Number of cases.
(1) Departed as temporary patient, relieved or recovered	2
(2) Departed as temporary patient, recovered. Readmitted as certified patient. Still in hospital	1
(3) Died as temporary patient	7
(4) Became voluntary patient. Departed relieved or recovered	7
(5) Became voluntary patient. Still in hospital	2
(6) Became voluntary patient. Departed relieved or recovered. Readmitted as voluntary patient. Still in hospital	2
(7) Became voluntary patient. Departed relieved. Readmitted as voluntary patient. Departed relieved	1
(8) Became voluntary patient. Departed relieved or recovered. Readmitted as certified patient. Still in hospital	2
(9) Became voluntary patient. Departed relieved or recovered. Readmitted as voluntary patient. Departed relieved. Readmitted as certified patient. Died	1

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	Number of cases.
(10) Became voluntary patient. Died	1
(11) Extended as temporary patient. Certified. Still in hospital	6
(12) Extended as temporary patient. Departed as temporary patient, relieved	1
(13) Extended as temporary patient. Became voluntary patient. Departed relieved	1
(14) Extended as temporary patient. Became voluntary patient. Certified. Still in hospital	1
(15) Certified. Died as certified patient	1
(16) Certified. Discharged, relieved. Readmitted as certified patient. Still in hospital	1
(17) Certified. Still in hospital	1

This list shows that out of 38 temporary patients only 12 have gone out and stayed out without being certified. Eight cases died without being certified; 14 cases were certified at some stage of their illness; 18 cases at some stage became voluntary patients. In effect, certification was avoided in rather over 50% of our temporary patients.

We know that Section 5 is an experiment, which our law-givers are allowing us to work, as the first instance of non-judicial interference with the liberty of the subject. Capt. Gunston said in the House of Commons, "We know that as a general rule one has only to mention the liberty of the subject and lawyers flock to the House, a sort of *habeas corpus* look comes into their faces, and they promptly imagine that they have been briefed in a case of St. George *v.* Dragon". At Cefn Coed we have tried to show that we have not abused the trust placed in us.

Dr. W. ROBINSON said: Since the year 1925, consequent upon the passing of the City of London Various Powers Act, uncertified private patients have been admitted into the City of London Mental Hospital.

From the beginning of the above-mentioned period until the termination of the year 1930, 383 private patients avoided certification and entered the hospital as direct admissions for treatment as so-called voluntary patients. Needless to say this title was not correct.

Since the operation of the Mental Treatment Act of 1930, 255 private patients have been admitted direct for treatment on either a voluntary or a temporary basis, and during the same period 48 private patients have been received direct under certificates.

Therefore, as regards private patients, the policy of receiving them without certification into a public mental hospital has proved a success.

Unfortunately, however, since the beginning of the year 1931 until the end of the year 1933, only one rate-aided patient has been received without certification. The number of rate-aided patients admitted direct under certificate during this period has been 50. In all probability at least 2 out of every 3 of the rate-aided patients admitted under certificate might have been sent to the mental hospital in question on either a voluntary or a temporary basis.

From this it will be gathered that where rate-aided patients are concerned the application of the provisions of the Mental Treatment Act has not had marked beneficial results.

The successful application of the provisions of Section 5 of the Mental Treatment Act, where private patients have been concerned, has been greatly due to close co-operation between the medical staff of the hospital and local medical practitioners. Consequent upon such close co-operation, after a medical report has been received relating to a private patient, and it has been decided to accept the private patient for treatment on a temporary basis, the patient's own physician has, in many cases, completed the second medical recommendation only at my request or on my advice. This medical recommendation has been brought by the relative who has accompanied the patient to the hospital. At the hospital the first medical recommendation has been completed by one of the medical staff. Thereupon the relative has filled in the application for the reception of the private patient to the

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hospital on a temporary basis. By such methods the admission of private patients on a temporary basis has been readily accomplished.

There is no doubt whatever that a lack of knowledge of the provisions of the Mental Treatment Act of 1930 has existed amongst general practitioners, even though some of these general practitioners have been approved by the Board of Control to make special recommendations under Section 5 of the Mental Treatment Act.

It is proposed to quote from a few of the completed medical reports which have been received at the hospital:

	Questions.	Reply.
CASE 1:		
	(*a*) Is the patient suitable for treatment as a voluntary patient?	Yes, but she will not sign the form.
	(*b*) Is it proposed to send the patient under certificates?	Yes.
CASE 2:		
	(*a*) Is the patient suitable for treatment as a voluntary patient?	Yes.
	(*b*) Is it proposed to send the patient under certificates?	Yes.
CASE 3:		
	(*a*) Is the patient suitable for treatment as a voluntary patient?	Yes.
	(*b*) Is the patient fit for treatment as a temporary patient?	Yes.
CASE 4:		
	(*a*) Is the patient suitable for treatment as a voluntary patient?	Yes.
	(*b*) Is the patient fit for treatment as a temporary patient?	Yes, say two months.
CASE 5:		
	(*a*) Is it proposed to send the patient under certificates?	Yes.
	(*b*) Is the patient fit for treatment as a temporary patient?	Yes.

Every permutation and combination of temporary, voluntary and certificates

Where rate-aided patients are concerned the responsibility for the apparent failure of the application of Section 5 of the Mental Treatment Act at the hospital in question must be shared by (1) external medical authorities, (2) public assistance officials, (3) justices and magistrates.

Attempts have been made to convey to such authorities and officials that it is easier to take advantage of the provisions of Section 5 of the Mental Treatment Act than to ignore them. It has been suggested to those concerned that the procedure adopted in the respect of the admission of private temporary patients to this hospital is almost equally applicable to the reception of rate-aided temporary patients. It has been pointed out to the medical authorities that if they will sign the second medical recommendation, the first medical recommendation and application for admission for treatment may both be completed when the patient arrives at the hospital in question. The statement that the adoption of this procedure in suitable cases would entail more expense than is at present incurred when a magistrate or justice is called in to sign the order for the reception of a rate-aided certified patient into a mental hospital does not appear to be founded on fact. It is obvious, too, that an intelligent attempt to apply the provisions of the Mental Treatment Act of 1930 would have, in many cases, prevented public assistance officials expending much time in attempting to obtain many particulars relating to the past histories of patients. Medical histories can readily be obtained after admission.

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Owing to the particular characteristics of the area from which rate-aided patients are sent to the hospital in question, it would appear that temporary rate-aided patients will in most cases, but not in all cases, have to be dealt with by the public assistance officials. It is considered, however, that at least in many areas of the country, the family physician might sign the second medical recommendation, and that the first medical recommendation and the application for treatment could be completed when the rate-aided temporary patient has been taken to the mental hospital. If such a procedure were adopted it would appear that there is no reason why a temporary patient of the rate-aided class could not be received at a public mental hospital without the relatives having to worry to any great extent the public assistance officials.

It is suggested that all justices and magistrates should endeavour to become fully acquainted with the provisions of Section 5 of the Mental Treatment Act, and that all justices and magistrates should refuse to sign an order for the reception of a rate-aided patient under certificate, unless they are satisfied that such a patient cannot be received into a mental hospital as a temporary patient.

The argument has been put forward that justices and magistrates will find it difficult to give an opinion as to whether a patient was capable or incapable of expressing either willingness or unwillingness to receive treatment. If members of visiting committees are called upon to express such an opinion after a temporary patient has been received into a mental hospital for treatment, it is thought that justices and magistrates should be considered competent to arrive at a similar decision.

There is no doubt that attempts to work successfully the provisions of the Mental Treatment Act have caused a great increase in the amount of work to be done in the mental hospital in question, by (1) the visiting committee, (2) the members of the medical and nursing staff, and (3) those employed in the clerical departments.

Consequent on the Act the committee has made an extra visit to the hospital each month. It has interviewed all voluntary and temporary patients, and it has considered a special report prepared by the medical superintendent in respect of each voluntary and temporary patient under treatment. Each month a list is prepared of all voluntary and temporary patients under treatment. The patients are interviewed by the medical superintendent, and a written statement is furnished by him and filed at the hospital to the effect that all the patients (if this be the case) whose names appear on the lists are fit to remain for treatment on either a voluntary or a temporary basis. Exceptions (if any) are recorded and the necessary action is taken in respect of regrading. This procedure has proved very useful, and it has prevented any controversy on the part of any visiting authorities as to whether a patient is fit or otherwise to remain for treatment in the hospital on either a voluntary or a temporary basis.

Numerous changes have taken place in the mental phenomena exhibited by both voluntary, temporary and certified patients during the period under review, and a considerable amount of re-grading has been necessary, but these changes have not proved insuperable, although they have undoubtedly increased the amount of work. Thus, for example, 102 private voluntary patients have had to be certified. Out of the total number of non-certified and certified patients admitted to the hospital during the period of eight years, re-grading has taken place in 145 cases out of a number of 1,076. In other words, re-grading has been necessary in nearly 15% of patients received for treatment.

The increase in the duties of the medical, nursing and clerical staff consequent on the more frequent reports required by the Board of Control in respect of temporary patients has been considerable.

The opinion is expressed that some of the reasons for the failure to make the application of Section 5 of the Mental Treatment Act a success as is alleged in some areas have been :

(*a*) Lack of knowledge of the provisions of the Act on the part of some general practitioners, of some medical officers of public assistance hospitals, of some public assistance officials, of some justices and magistrates.

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(*b*) Apathy on the part of some visiting committees and some medical authorities in some mental hospitals.

In conclusion, it is considered that the Mental Treatment Act at the hospital with which I am associated has been a success. The application of the Act has meant increased work, and extensive propagandism. A conscientious attempt to apply the Act will be rewarded by an increased confidence on the part of the public in mental hospitals and their administration, and a breaking-down of old barriers.

In the future I feel confident that the Mental Treatment Act will be regarded as a Magna Charta in the treatment of mental illness.

Mr. L. G. Brock (Chairman, Board of Control): Mr. President, Ladies and Gentlemen,—I had not meant to speak this afternoon, and, if I had, I would rather have waited until a later stage in the discussion. But since you have been good enough to ask me to speak I cannot refuse your invitation, because I feel that the question you are discussing this afternoon is a very important one, one on which the help of the Association is very badly needed. Like my colleague Sir Hubert Bond, though I feel that progress up to date is disappointing, I certainly would not speak of the results which have been achieved as a failure, as I think any new procedure must inevitably take a considerable time before all those concerned can become sufficiently familiarized with it. One of the greatest difficulties, as has been pointed out by previous speakers on the subject, is not a difficulty which rests with you, or which it is easy for you to correct. I think the apathy and the indifference of the public assistance authorities, and the unwillingness of relieving officers to adopt a procedure which is different from the procedure which they have been accustomed to adopt, which means a new routine and a certain amount of extra difficulties, or what may appear to be difficulties, is largely responsible. To overcome, in some measure, that obstacle we propose, with the concurrence of the Minister of Health, to issue a circular letter to local public assistance authorities and visiting committees, enclosing a short memorandum for the guidance of relieving officers, designed to show that the difficulties of securing rate-aided admissions under Section 5 are a great deal less than they are commonly supposed to be. It has been felt to be a difficulty that one of the two signatures to be obtained has to be the signature of a doctor on the approved list; but, as Dr. Robinson has pointed out, it can be overcome by leaving the second signature until the patient actually comes to the hospital. The main difficulties which have been experienced in working the Section so far are the difficulties of educating public assistance committees and relieving officers, and the difficulty of educating the general practitioner. I suggest that it would help very much to educate the practitioners if, when cases come to your hospitals which, in your judgment, are properly to be regarded as non-volitional, which might be dealt with under Section 5, you would ask the doctor and ask the public authorities why Section 5 was not used.

If you would point out, with reference to particular cases, that they might have been brought under Section 5, and if you could show how that could be done, and could point out the steps which might have been taken, it would do as much as anything to educate those responsible for the working of the machine to adapt themselves to the procedure. I know there are some who say that the difference between a temporary patient and a certified patient is very much a matter of label. That, however, is a view which I cannot accept. It is true that whether the patient comes under Section 5 or whether he comes as a certified patient he has got to be associated with certified patients, he has got to be treated with reference to his mental condition, and not with reference to his status on admission. It is said it is the association with a mental hospital which brings the stigma, not the legal form under which he is admitted. I do not think that is true. I have seen letters from relatives of patients complaining bitterly that they might have been admitted without certification. While it may be true that so long as the patient is in a mental hospital it does not make much difference to him or to his friends whether he has been admitted under certificate or not, I am sure it makes a great deal of

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difference to him if and when he comes back into community life again, because certification does mean a stigma—however unreasonable and illogical the idea may be—and leaves a permanent mark on the man or woman, and if it can possibly be avoided I am sure it is a real benefit. That it is generally felt to be a handicap is strikingly proved by the efforts which are made by the relatives of the better-off patients, and by medical advisers to avoid certification. And, taking the returns of 1933, we find that the patient who is well enough off to come as a private patient has eleven times as good a chance of escaping certification as the rate-aided patient has. If the private patient and his family find it worth while to go to so much trouble, to take so much pains to avoid certification, it is difficult to argue that certification is not a real handicap and does not impose a stigma. Any help which the Association can give—and it can give a great deal—in inducing medical practitioners and public assistance officers to avail themselves of the new procedure will, I am sure, make a very great difference.

But do not let us be disappointed because, up to date, the progress in this matter has been very slow; it always takes time to familiarize people with a new procedure, to teach them a new routine; and though we are disappointed with the progress which has been, so far, recorded, I am glad to say that the latest figures show a distinct improvement. The figures relating to the rate-aided admissions under Section 5 for last month were the best we have yet had. It cannot be called a sensational change, but I think that the figures which come to me month by month show that there is a steady, though slow, rise in the curve, and I am sure that the more we can discuss this matter, the more we can pool our experiences and analyse the practical difficulties which have been met with, the sooner we shall succeed in putting the Section into effective operation, and the nearer we shall get to the stage when the treatment of mental disorders will be left to be decided on medical advice, and not on judicial authority.

Dr. W. R. DAWSON said that about two years ago, namely, on October 1, 1932, an Act, which was largely similar to this English Act, came into operation in Northern Ireland. In the drafting of that Irish Act the speaker had a good deal to say, but as he retired from his connection with the Government of Northern Ireland four years ago, he had not had any experience in a practical way of the working of the measure. He had had, however, a communication from his successor and very good friend Dr. Patrick with regard to the working of the Act, and it might perhaps interest the meeting if he were to give a few of the figures. Figures were so far available for only one year, as there had been only one complete year's working. These figures, which dealt with 1933, had not yet been published.

With regard to the public mental hospitals, he found that in 1933 the admissions numbered 1,227, and that of those only 63 were temporary patients. Yet that represented a proportion of 5·1% temporary patients out of the total admissions. It was a higher proportion than appeared to obtain in this country. The great majority of the cases he was referring to were admitted to two hospitals, one the largest—the Belfast Mental Hospital—the other the Downpatrick Mental Hospital. Only one mental hospital received no temporary patients at all. Of others, one received 2, another 8, another received 1. If one omitted Downpatrick and Belfast Hospitals the number of such patients admitted was negligible; still it was very general, and he thought it very encouraging that in the first year there was only one hospital which did not receive at least one temporary patient. Of the temporary patients who were admitted, 10 had to be certified subsequently. That was not at all bad, he considered, for the first year.

In regard to the private mental hospitals, he felt some hesitation in giving the new figures, as there were only two private mental hospitals, and the total admissions only a small number, namely 42. Of these there were admitted to the two private mental hospitals 23, or nearly 55%, temporary patients.

As to the discharges, he found that in the public mental hospitals 23 were discharged recovered, and 14 of the 53 discharged were improved or relieved. That he regarded as a satisfactory proportion of recovered and improved.

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Note.—To complete the figures, it should be added that 121 voluntary patients were admitted to the public mental hospitals, or nearly 12% of the total admissions; while the two private institutions received 13 voluntary patients, or nearly 31%.

Dr. M. ABDY COLLINS said he would like to avail himself of this opportunity to give the meeting a few points regarding the working of the measure in a country district. There was first the reason for the difference in the use of the Section for private as opposed to rate-aided patients. In the case of private patients the second signatory was usually a person who had had considerable experience of mental trouble and understood the meaning and scope of Section 5, yet many who were required to sign the document made more mistakes in regard to it than anybody else. If there was a mistake made in the form, it was usually found to have been made by a general practitioner. He and his colleagues generally tried to overcome that by filling in and completing the form after the patient arrived at the institution. In several cases that method had been quite successful.

In working out the figures, much depended on the type of patient admitted to the hospital. In the district in which he was placed, the mental defectives were only four less than one-tenth of the number ascertained to exist. He therefore received a very large number of defectives, who had become so troublesome that no one would tolerate them anywhere else. That state of things was being remedied, but it meant that his institution got a large number of people who were not fit for treatment as temporary cases.

With regard to urgency orders, surely a patient admitted under an urgency order could be dealt with as a temporary patient during the week that the urgency lasted; because an urgency order had been used that was not to say it precluded the patient being treated as a temporary one.

Another trouble was the following: Arrangements were made for these people to be seen in outlying districts by members of the visiting committee, and he was in a place where there was sometimes great difficulty in getting this visiting done. No doubt some improvement was evident, even to the extent of a gentleman coming as a temporary patient and driving himself 25 miles to the hospital, and then stating that he was unwilling to remain!

Dr. WORTH remarked that, so far, the meeting had heard those who were advocates of Section 5 of this Act. He thought all the members appreciated —as he did himself especially—that the Mental Treatment Act, 1930, was a great advance on the old Act. There were two provisions in it which struck him as excellent: (1) that the public mental hospitals were enabled to take voluntary patients, (2) that patients could be admitted to public mental hospitals under an urgency order. The Temporary Order, however—he admitted he might be regarded as a voice crying in the wilderness—did not appeal to him very much. He said that for the following reason. Mention was made by Mr. Brock of the stigma of a patient being certified; he, Dr. Worth, saw little difference between the stigma of certification and the stigma attaching to a patient who entered a mental hospital as a temporary patient. In after life, or in the community to which the patient afterwards returned, it did not seem to make a great deal of difference what was the particular cause of the stigma; the main fact which the public took note of was that the persons concerned had "gone off their heads" and so had had to be treated at a mental hospital. He considered that the advantage of certification was that a patient who was certified did come under the law, and his or her estate was protected. If Section 5 was to be useful and serve the purpose for which it was framed by those who projected it, it should be pointed out that the ordinary practitioner could, in any case, use an urgency order to send a particular case to a mental hospital, and it was for the mental hospital authorities to decide whether such case should be voluntary, temporary or certified. He emphasized that for seven days that case had the advantage of expert advice and expert supervision by those who knew the case and could arrange it accordingly. In his hospital, one in the Home Counties, which was, therefore, easy of access, there

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had been only about six temporary cases since the passing of the Act, and some of those six had had to be certified, hence only two or three had remained as temporary patients.

He agreed there might be a sort of sympathetic consideration for the person who came under Section 5 of the Act, but he could not see all the advantages which some attached to it. If he himself should have a relative who passed over the mental borderline, he would prefer that he entered a mental hospital not as a temporary patient, but as a certified one. Another consideration was that it was difficult to say, in a given case, whether the person had or had not sufficient volition to know his own mind.

Dr. SERGEANT thought that Dr. Worth had been very provocative. There had been a good deal of confusion of thought about this matter. It was impossible to ignore the fact that the stigma of certification did exist, though all agreed it was quite unecessary in any reasonable society. But we did not move in reasonable society, therefore it was compulsory to admit the existence of the stigma. It was a bogey which had been manufactured by the ignorant population of these islands. It was said that the remedy was education, but the educational task was shirked, and something was palmed off which would satisfy the public and yet be less onerous. On this idea it was decided to get people to come for treatment without certification. It was admitted that the stigma was an unreal one, but British people had a faculty for expediency, and this scheme was a matter of expediency. If these points were grasped the matter would become much clearer. It was insisted that there was a difference in these patients in the matter of stigma, because by the lawyers they were classified as voluntary or temporary, and as certified. If he might criticize both the Board of Control and *The Times*, he would say it was recognized that a stigma attached to a mental hospital however well it was run.

Reverting to the question of expediency, the public could not be educated on the matter, therefore an expedient measure was introduced to persuade the public to come for treatment as notified, not certified, patients. There was no difficulty in the Act itself, only in its interpretation, and with that the medical officer had nothing to do; he would rather have them all voluntary. The medical officer was there to treat; it was left to officials, lawyers and laymen to interpret the Act. No one, for instance, had yet defined " willing " and " unwilling ".

He would tell them of a case he had had admitted as a voluntary patient. This patient was discharged relieved, and after an unhappy experience at home he clamoured to come back, but was not allowed to. He ran away, and was found hiding in the speaker's garden. He took it that constituted volition. He had remained a voluntary patient ever since. Legal doubts were expressed as to his remaining a voluntary patient because he refused to say he wished to remain, but actions stood for more than the spoken or the written word.

All doctors would wish all patients to be voluntary or temporary if they could; the trouble arose with the official mind, the legal mind, or the lay mind, and if any doctor could be assured that what experts said was good enough and that they would have the backing of the official, the legal and the lay elements, he thought the mental hospitals would be full of voluntary and temporary patients. Therefore concentration should be devoted to persuading legal and lay people to give doctors all the backing in their power.

The PRESIDENT wished to make only two remarks. The first was the pleasure with which he read, in the Commissioners' last Report, Part I, how well the registered hospitals and licensed houses were carrying out the law. The general practitioner knew little about certification, and nothing about temporary patients, whereas patients who came to registered hospitals or mental hospitals had seen one or two consultants, who did know something about the law of the country.

The other criticism he would make was the following: It had been found in practice that the temporary patient system was very useful for patients suffering from alcoholic insanity, but he thought that the period given in the Clause, which

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stated that patients must be discharged 28 days after return of volition, was too short. Those people would not remain on as voluntary patients, and they returned too soon to their former intemperate ways. That, he thought, was a point which might well be borne in mind when any change in the Act was contemplated.

ANNUAL MEETING, 1934.

The following paper and discussion were held over from the October, 1934, number.

MODERN PSYCHIATRY AND MENTAL HOSPITALS.

By HENRY YELLOWLEES, *O.B.E.*, M.D.Glas., F.R.C.P.E., M.R.C.P.,

Physician for Psychological Medicine, St. Thomas's Hospital.

This paper is a review of a situation. The situation I purpose to review is one with which this Association is vitally concerned. I need not remind you that to our Association belongs a vast share of the credit for organizing and carrying out the teaching and training of generations of mental nurses, for marvellously enhancing the prestige of psychiatry among the profession and the laity, for earning for our mental hospitals a reputation unsurpassed throughout the world, and for that almost incredible amount of selfless and tireless effort for the welfare of the insane which is our honourable tradition and which is its own reward.

Up till the war, the great majority of practical improvements, discoveries, researches and reforms in connection with psychiatry emanated from mental hospitals. There was, of course, plenty to reform, and it was very fitting that reform should originate from within, but I am referring to something far wider than the improvement of asylums. I am referring to psychiatry as a whole and in every aspect, and I repeat that it is hard to think of any real advance which did not owe its inception to someone who was intimately associated with mental hospitals. I need not remind members of this Association of the list of so-called " asylum men " who have brought honour to themselves and the specialty by their ability and devotion either in reform, administration or research. Beginning from the days of Tuke at the York Retreat, one thinks of Connolly at Hanwell, of Gardiner-Hill at Lincoln, of Laycock, of Hack Tuke, of Skae, of his great pupil Clouston, and the wonderful group of Scottish psychiatrists of his time, of Maudsley, of Savage, of Mercier, of Bedford Pierce, of G. M. Robertson, and many others—to say nothing of their eminent successors who are still with us, or of the multitude of less known men who are advancing the specialty little by little far away from public note or notoriety as they have ability and opportunity.

The post-war epoch is a convenient and accurate enough landmark to date the change which has come about. This change is associated with two developments of great importance. The first is the enormously increased amount of attention devoted to research, which, of course, means a greatly increased number of research workers. You all know, though I question if the public or the profession in general does, how the mental hospitals have reacted to the situation. In the great majority of mental hospitals of any size and repute whatever, there are clinical and pathological laboratories whose staff and equipment compare most favourably with those of any general hospital in the country.

In saying that the mental hospitals met the situation by providing laboratories, I am, in fact, doing them less than justice. In many instances the laboratories and the staff and the interest were there long before the profession as a whole had begun to " sit up and take notice ", and much patient, skilled and pioneer work was being turned out from these laboratories even in the days when popular opinion still believed mental hospital staffs to be entirely composed of persons

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