Medical and general reports and accounts for the year ended 31st December, 1942 : (from Swaylands, Penshurst, Kent.) Present Address: Ash Hall, Bucknall, Stoke-on-Trent / The Cassel Hospital for Functional Nervous Disorders.

THE CASSEL HOSPITAL

FOR

FUNCTIONAL NERVOUS DISORDERS

(Founder: The Right Honourable Sir Ernest Cassel, G.C.B., G.C.M.G., G.C.V.O.)

PATRON:

HER MAJESTY QUEEN MARY.

Medical and General Reports and Accounts

FOR THE YEAR ENDED

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(From SWAYLANDS, PENSHURST, KENT.)

Present Address: **ASH HALL, BUCKNALL, STOKE-on-TRENT.**

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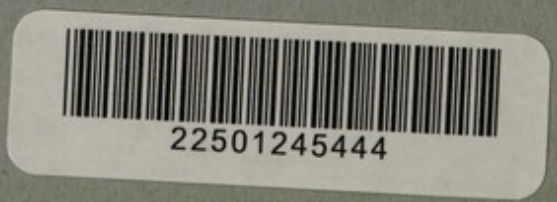

The Cassel Hospital for Functional Nervous Disorders.

(Founder: The Right Honourable Sir ERNEST CASSEL, G.C.B., G.C.M.G., G.C.V.O.)

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THE MEDICAL DIRECTOR'S REPORT.

THE PROBLEM OF REHABILITATION IN THE NEUROSES.

1. *INTRODUCTION.*

The Tomlinson Report.

Early in 1942 the Medical Director was requested by the Medical Committee to devote special attention to the problem of Rehabilitation in the Annual Report for the year. The publication of the Tomlinson Report has made this request a particularly timely one, and has brought to a focus the growing interest in the whole problem of Rehabilitation.

It is a matter for congratulation that the Tomlinson Report should have appeared at the present time and its stimulus will be widely felt. Though many of its suggestions and recommendations appear admirable, there are others which are open to criticism. In particular the concept of rehabilitation which it sets forth has not always seemed broad enough to meet the needs of the problem. The definition given in paragraph 5 appears to be an unfortunate one—" Rehabilitation in its strictly medical sense means the process of preventing or restoring the loss of muscle tone, restoring the full functions of the limbs and maintaining the patient's general health and strength. (This is apart from special rehabilitation treatment required for particular diseases such as tuberculosis.)" This is a narrow and somewhat muddled view of the subject which is fortunately belied by the body of the report.

Psychotherapy and Rehabilitation.

In the study of this subject it is fatally easy to fall into a habit of contemplating the human individual in terms of his disordered parts and not as a socially integrated whole, the parts of which can never be healthy unless the whole is functioning efficiently. In the field of psychiatry it is always necessary to consider the individual, his illness and his background as a whole and it is, therefore, especially appropriate that the Annual Report of the Cassel Hospital should be devoted to the subject of Rehabilitation.

Definition.

The following definition appears to summarise what is intended by the term " Rehabilitation " and to include under one broad heading the various measures which have been proposed.

" Rehabilitation is treatment with a purpose. The purpose is to ensure not merely the repair of the diseased organ of a patient, but his fullest possible return to normal life in a setting designed to prevent the recurrence of the disorder. To this end all available resources, physical, psychological and social, have to be employed to the best possible advantage."

Such a definition includes all that is at present undertaken in medical treatment and more besides. Rehabilitation in this sense must begin with the first contact which is made with the doctor or nurse, and it must be the goal of every subsequent step. Thus considered, it becomes not just a question of graduated exercise and better plans for convalescence, but a better orientation towards all the problems of clinical practice. No Government plans, nor subsidies nor the creation of special " rehabilitationists " can suffice to bring this about. Much of the change must come from within the medical profession itself, from its teaching and its outlook. Because this attitude towards treatment must of necessity be achieved by the psychotherapist if he is to succeed at all, it may be that a discussion of the problem as it affects the psychoneuroses may have wider and more general implications.

Basically the stages of medical treatment in all types of disease have much in common. The first stage consists of the elimination of noxious agents and the application of the principles of rest, the second stage sees the gradual restoration of function, and the third stage the final return to normal life. These steps are equally familiar to the orthopaedist, the psychiatrist or the specialist in tuberculosis. They call for the use of different techniques at different stages, but to be really effective they must all be welded together by an enlightened view of the patient and his problems as a whole.

Stage 1.

In a broad survey of the problem of rehabilitation, the first stage of treatment must be considered as fully as the later ones. Frequently this is not done, so that an unreal division is created between medical treatment and rehabilitation which is most unfortunate.

It is obvious that major advances in treatment depend upon the whole progress of medical science, and are best considered under their own special headings, but there are certain matters of general importance which should be discussed at this stage.

For example, since prevention is the best means of cure, any steps which will tend to prevent " dehabilitation " (if such a word may be coined) must surely be of importance. In the field of the neuroses many possibilities for such preventive action exist, particularly in those cases in which the neurosis

arises in a patient who is already under medical care for a physical disease. Such " iatrogenic " neuroses are fairly common. Again, since a neurosis which has become chronic presents an exceedingly difficult problem, more adequate provision for early treatment must also be highly relevant. Lastly, there is one aspect of treatment which appears at every stage and which is still in its medical infancy, namely, the provision of the most effective occupational therapy. There is a great field for progress in all these matters.

Stage 2.

The next stage, which is too often the first to be considered in connection with rehabilitation, covers that delicate period when the patient is fit to leave the hospital, but is not yet capable of leading a normal life. The gap between hospital and working life is the one which requires the most careful bridging, and is the point at which failure occurs most frequently in the treatment of psychoneuroses, as also in the treatment of many other medical and surgical conditions. There are, of course, a number of patients who proceed quite readily from hospital to working life, but many find this a very difficult step. It may be worth while at this point to consider what arrangements can be made at the present time for the patients under our care.

Some are fortunate in that they are able to afford a short period of convalescence before returning to work. This they may spend either at a holiday resort or at an ordinary convalescent home or with their families at home. Any of these may be an excellent arrangement in certain cases, and it is our habit to send patients who have recovered from depression away for a holiday as a routine procedure before they return to work, particularly if they have had electrical shock therapy. For others, however, and particularly for the long-standing neuroses, the arrangement is not a good one. They come from a hospital atmosphere in which they have usually been happy in the society of other patients whom they have grown to know well, they have been leading a well regulated and fairly well occupied life. They would find a sudden return to full normality more than they could stand. Idleness at home, often in the atmosphere in which the neurosis was generated, is a bad alternative. There is at present no convalescent home which will provide for them quite the environment which they need.

Stage 3.

For the patient who has passed successfully through this second or convalescent stage of his recovery another problem may arise, that of the third stage of rehabilitation, the period of return to work. Occupational difficulties, due to unsuitable or unsatisfactory type of work, or to lack of any work at all, are important contributory factors in the aetiology and maintenance of a neurosis. Such factors were constantly occupying our attention before the war, but at the present time they have become mercifully greatly reduced.

It may be worth while to recall that in the Annual Report for 1941 it was demonstrated that, so far as we were able to ascertain, there had been no material increase in the total incidence of neurosis among the population served by this hospital. At the same time it was pointed out that there were a number of patients whose illness had definitely been precipitated by war conditions. The number was comparatively small but it was sufficient to suggest that, as the total incidence did not appear to have changed, there must also have been a number of patients whose condition had improved as a result of the war. Investigation has shown that this assumption is correct. Out of a total of approximately 200 patients treated during the last two years we have estimated that 20 have benefited to a material extent by finding work which satisfied them, sometimes for the first time in their lives. Government training schemes have aided some, others have been happier in the Forces than ever before (a reminder that the indiscriminate rejection of patients with a history of neurosis may not always be wise). Still others with the bogey of unemployment no longer in front of them have dared to change their jobs.

The following is a typical example :—

Case 1.—Mr. H., aged 42, was admitted to the hospital in a state of considerable depression and agitation. He had been drinking excessively for some years and had gradually become more despondent about himself. At the same time his physical health had deteriorated and he had developed peripheral neuritis.

He was the only son of wealthy parents and possessed abilities beyond the average. He had never had to earn his own living and so had frittered away his time earning practically nothing, and not having the impetus to stick to anything consistently. He had gradually taken to whisky as a solace from boredom and dissatisfaction.

His condition improved quite rapidly in the hospital, he was a thoroughly co-operative patient and he took a keen interest in occupational therapy. It was obviously necessary to find for him some worthwhile occupation, and this would have been a difficult problem in peacetime. However, he had some mechanical skill and he agreed to take a Government course of training as a fitter in order to do useful war work. He was able to attend the official training centre, whilst still a patient in the hospital, and he was delighted to find that he had discovered his true bent. He proved to have very great mechanical aptitude and, after completing the course, he was sent to do important repair work at a factory. He

was discharged from the hospital in February, 1942, and has been doing this work ever since without further depression or recourse to alcohol.

The following patient presents a further example of progressive rehabilitation which would not have been possible but for the changed labour condition brought about by the war.

Case 2.—Miss C., aged 28, was admitted to the hospital on account of headaches and insomnia. She was the only daughter in a family of five, her childhood was normal, though she was rather spoiled. At the age of 15 she had an epileptic fit. She was working hard for an examination at the time and she was also taking part in many athletic activities. A consultant advised that she should continue to lead a normal life, but that she should restrict her activities slightly to avoid fatigue. Unfortunately, her mother took note of the second part of his advice but not the first, with the result that the patient was treated like an invalid. She did hardly any useful work although her fits were of a minor character and very rare. She gradually became more and more self-centred, introspective and over-anxious.

In hospital she was given a most thorough physical examination and this was followed by explanation, reassurance and re-education. She was caused to lead a normal life in hospital, taught what things (e.g., alcohol and too many late nights) she had to avoid and shown that she must develop her interests and ambitions in order to be happy.

On discharge she was able to get a part-time job in a library owing to shortage of staff. This proved to her that she was capable of earning her own living and probably did more to help her than all our reassurance. Indeed, it is probable that if such "light" work had not been available (as is usually the case in peacetime) she would not have succeeded in making a start at all. After a few months in the library she took up secretarial work and now has full-time employment in the office of a chartered accountant. She is well and happy. In both these cases the neurosis depended to a considerable extent upon the lack of adequate and fruitful occupation leading to boredom and dissatisfaction. In one patient the reaction was to seek refuge in alcohol, in the other anxiety symptoms developed.

There is one further factor in these and other cases which certainly deserves mention. Both the patients quoted have improved, or at least maintained their improvement, as a result of satisfactory occupations. It is doubtful, however, if the occupations considered as ends in themselves, would be sufficient to account for the change. There is in both these patients a sense of pride in being a part of the national war effort which is a source of gratification to them and gives them the feeling of belonging to a larger pattern. They are not fighting just for themselves but for their country. This is a spirit of which too little was heard before the war, but in our experience it is a powerful incentive for a neurotic patient who is being asked to give up many old sources of gratification in order that he may become a useful member of the community.

2. *DEVELOPMENT OF REHABILITATION AT SUCCESSIVE STAGES OF TREATMENT.*

Stage 1.

In connection with Stage 1, which is roughly synonymous with the period of hospital treatment or at least of intensive medical treatment, certain points have already been mentioned. These may now be amplified.

Early Treatment.

With regard to the problem of early treatment, experience in wartime has taught the psychiatrist a very valuable lesson, namely, that acute symptoms of anxiety which if untreated might readily become persistent and incapacitating can often be relieved by appropriate treatment undertaken within a few hours or days of their onset. Moreover, having been thus quickly eliminated they show much less tendency to recur than do anxiety states which have become chronic. This is in line with peacetime experience in this hospital which led us to the conclusion that the early treatment of an anxiety neurosis was a matter of the utmost urgency. Indeed it appears likely that certain cases would never have suffered a neurosis at all if adequate steps had been taken to counter their fears at the beginning. This applies particularly to patients whose psychological difficulties followed a physical illness in the first place.

Whenever a patient is ill, from whatever cause, he is bound to feel anxiety. His anxiety may take many forms, it may be mainly financial and be concerned with his family or his job, or it may be personal and concern his own future. Whatever the cause, the doctor should be trained to watch for this anxiety and be prepared to deal with it. There is at the present time a growing and thoroughly convincing body of evidence concerning the morbid effects which unpleasant emotion may produce upon the physiological functions of the body. The cardio-vascular, respiratory and alimentary systems are all affected in quite obvious ways and there are other less evident associations. For example, T. B. Layton has pointed out the fallacy of a strict policy of isolation for children suffering from chronic suppurative condition of the ears. Shut up in little cubicles these children are thoroughly miserable and, as a consequence, the tone of the muscles of their face and neck (i.e., of the muscles of facial

expression) is poor. If they are allowed to play and be happy the muscle tone is improved and the drainage of the infected areas is thereby augmented.

The relief of anxiety and unhappiness is therefore among the first steps in the process of rehabilitation in all types of disorder. The relief of financial worry is one of the most important of these and it necessarily depends in many cases upon the State rather than upon the individual physician. It is, however, important that the physician should be aware of the existence of such worries and that he should do all that lies within his power to make others aware of their importance from a medical as well as from a social standpoint. The relief of worry about health is very much the business of the physician, and there are a number of particular worries which frequently serve as the starting point of a chronic neurosis.

Especially worthy of mention are the psychological symptoms which arise from a failure on the part of the physician to explain adequately to the patient the meaning and probable course of his illness. For example, a patient was referred to this hospital suffering from severe anxiety symptoms. Their onset dated from the occasion on which he visited an orthopaedic surgeon complaining of pain in his back. He overheard a conversation between the consultant and his doctor in which his condition was termed "spondylitis deformans." The name terrified him and he felt sure that he was the victim of some terrible and fatal malady. A rather cumbersome spinal brace which was ordered for him did nothing to reassure him and he brooded over his condition until he became really ill with fear.

If such anxiety symptoms are detected at an early stage by an understanding physician the process of rehabilitation will have begun at the proper place. The power of the human psyche to adapt itself to limitations however crippling is a remarkable phenomenon. It is not the known disorder which frightens a patient but the unknown one. Our experience suggests that it is almost invariably better to give an accurate and intelligible account of the nature of the condition however serious it may be. To give bad news to an already depressed and anxious patient may seem an unwise step but it is remarkable, when the worst has been told, how the hidden resources of the psyche can be mobilised to meet it.

These aspects of rehabilitation demand provision which are outside the scope of this report to discuss. Among them must be a better education of doctors and nurses in the recognition and treatment of emotional difficulties in their early stages, and better provision for the early treatment of neurosis when it has actually developed. This latter step is very important for if the real magnitude of the neurosis problem was suddenly recognised, the waiting lists of hospitals such as this, already large, would become prohibitive.

Occupational Therapy.

Within the hospital itself, occupational therapy is one of the important ancillary services for the treatment of the psychoneurotic patient. It should be carefully adjusted to provide the right degree of interest and effort for the patient without overtaxing him. If it succeeds in doing so it can be of tremendous value, but if it fails in either of these respects it is worse than useless. The work of K. Goldstein upon patients with deficiency of cerebral cortical function amply illustrates this point. When the task set is within the limits of the patient's capacity and within his sphere of interest, he is often capable of surprisingly high achievement with corresponding benefit to himself. When the task becomes too difficult or lacking in interest his failure is greater than might be expected. He regresses in fact to a much lower level of performance.

It is the task of the occupational therapist in collaboration with the physician to ensure that the work provided fulfils these basic criteria. Within these limits occupational therapy is capable of many developments. Not every patient benefits from the orthodox crafts at the disposal of the occupational therapist. Some prefer to undertake work which is likely to be beneficial to the hospital or some other organisation. Provided the medical value to the patient of the work done remains the standard of reference, this may be widely encouraged. Indeed at the Cassel Hospital during the past 12 months, practically all of the gardening, some domestic work and even some responsible cooking has been done by patients.

Those who have learnt a craft have derived most benefit from it when it has been geared to a useful objective. Fortunately at the present time such objectives lie close at hand. Many women patients have worked for the Comforts Fund of the W.V.S. and some male patients have made excellent toys for the Children's Hospitals and Day Nurseries out of scrap wood. This is occupational therapy at its best, combining the sense of individual achievement with the sense of worth-while purpose. It is an exceedingly important part of "Stage 1" rehabilitation, and for its full development the occupational therapist must take a wide view of her responsibilities. She has to be proficient in her basic crafts and in their application to the treatment of the sick. She has also to collaborate with the Nursing and Domestic Staff to make occupational therapy a part of the accepted tradition of the hospital, and she has to keep in touch with outside social agencies and others in order to bring the activities of the patients into the best possible relationship with the world of reality.

Stage 2. Convalescence.

At Stage 2, when the patient is ready for convalescence, our present provisions are most scrappy and unsatisfactory. The lack of adequate convalescence, as opposed to the mere passive process of exposing oneself to a "change of air" in some neutral surroundings, is economically wasteful. A number of patients come to the end of the period when they need to be in hospital under close medical supervision, some time before they are ready for normal life. Not all of them require the same type of convalescence. For some a brisk, active toning-up process with a minimum of medical fussing would be ideal. This would not require to be carried out at a centre specially for psychoneurotic patients. Indeed, it would probably be better to accept all types of convalescent patients capable of benefiting from the regime. A strictly limited stay would be necessary, otherwise the brisk and hopeful atmosphere would be dissipated. No doubt something of this type is envisaged in paragraph 23 of the Tomlinson Report which speaks of "a course of reconditioning which should include organised games and graduated exercises."

Special Centre for psychoneurotic patients.

There are, however, other patients no longer requiring strict hospitalisation but for whom constructive discipline, care and supervision is still necessary. This group contains some long-standing neuroses of all types, certain psychopathic personalities and a few whose home environment is very bad. In many cases these patients are not capable of making an abrupt return to normal life, and for them the process of rehabilitation via the type of convalescent home mentioned in the previous paragraph is not suitable. They require some establishment where they can live for a time under occasional medical supervision, but without the close protection of a resident medical and nursing staff. The Supervisor of such an establishment should preferably be a trained nurse since her training would give her the proper background for her work. She should, however, aim at achieving a role which might best be described as that of "house mother."

One would visualise that most of the domestic duties in such an establishment would be carried out by the patients. There should be a sufficiently large garden to occupy some male convalescents quite fully. Work for these patients should be a condition of residence and should enable the cost of the establishment to be kept at a minimum. Other patients residing at the home would go out to work, either to their normal occupation in neighbouring towns or to some Government or other training centre. Residence in such an establishment should be limited to a maximum of (say) six months. It could serve a most useful purpose in reducing the pressure upon the available beds of the parent hospital.

Stage 3. Re-settlement.

Stage 3, Rehabilitation or Re-settlement, is a period during which direct medical contact with the patient is reduced to a minimum. The Tomlinson Report makes a series of recommendations upon which one is not qualified to comment adequately. In the field of neurosis among the civilian population the problem at present resolves itself into one of collaboration with the local officials of the Ministry of Labour and with individual firms to ensure correct placement of the patient, and to prevent undue strain from being placed upon him. Our experience with our local Labour Exchange has been a very fortunate one, and we cannot speak too highly of the skill and thoughtfulness which members of its staff have exercised on behalf of our patients. It is obvious that the conditions of total warfare have caused the Labour Exchanges to assume an altogether new significance in the lives of many individuals who had no previous contact with them. To judge by our experience they have borne their new responsibilities with great success. It seems altogether possible that with suitable staff they might become the main channels through which re-settlement schemes should operate, collaborating both with employers and physicians to this end.

With some employers, too, our experience has been satisfactory, particularly when it is possible to discuss the patient's difficulty with someone who has authority to see that agreed recommendations are actually carried out. The increased employment by larger firms of responsible welfare officers ought to make this process more efficacious in the future, whilst in the case of smaller firms the more direct personal contact between employer and employee often serves the same purpose.

Comparison with Tomlinson Report.

These, then, are the three stages of rehabilitation in the neuroses as we visualise them. They correspond quite closely to the stages of medical rehabilitation, post-hospital rehabilitation and resettlement discussed in the Tomlinson Report. There is one respect, however, in which we feel bound to differ from the recommendations of that report. Too sharp a division appears to us to be made in the report between these various stages. In paragraph 39 the creation of a Diploma is suggested presumably to qualify those who will endeavour to bridge the gap. In the field of the neuroses, however, our experience leads us to deplore such sharp divisions and to deprecate the creation of specialists in rehabilitation. We have after all only one patient to consider at all these stages, and the physician who has supervised his passage through Stage 1 should be capable of continuing the work to the end. If he is unable to do so the patient's treatment must inevitably suffer as a result of the break.

In general, during his period of hospital treatment the patient will be under the care of one physician who will carry his medical treatment as far as may be required. During his convalescence he will not need to have intensive medical treatment, or if he does he should be referred back to the psychiatrist who sent him. Clearly the convalescent home must be under medical guidance, but this does not mean that its medical superintendent will take over the function of the patient's own physician. The bulk of the programme of rehabilitation at this stage should in fact be carried out by ancillary personnel who have been adequately trained in their special work. This work would represent a particular branch which might be undertaken by nurses, massage staff, or occupational therapists, according to the type of rehabilitation and the nature of the institution in which it was to be carried out. For example, in the short-term type of convalescent home, massage staff would probably play a considerable part, whereas in the longer-term reconditioning unit for neurosis, already discussed, a trained nurse with special interests would be the ideal person to take charge. If, for these ancillary workers, a special diploma in rehabilitation is available, and if this is intended by the authors of the Tomlinson Report, then this suggestion seems to be an admirable one.

Role of psychiatric social worker.

Experience in this hospital and elsewhere leads us to make one further suggestion. The trained psychiatric social worker can be a very valuable ally in plans for all stages of rehabilitation. She can enter into and attempt to modify difficulties which may exist in the home. She can interview employers and explain to them the medical point of view concerning a patient, she can discuss questions of suitable employment with the officials of the Labour Exchanges, and enable them to grasp essential medical and social points. In the after-treatment of neurosis she can undertake for the physician work that he has neither the time, nor usually the knowledge, to do himself.

At the Cassel Hospital the fact that patients have always come from every part of the British Isles has prevented the employment of a full-time psychiatric social worker. It will be necessary to ask the Committee to consider after the war whether the obvious difficulties can be overcome, particularly as regionalisation may reduce the geographically scattered nature of our intake.

3. *SUMMARY.*

Experience at this hospital leads us to suggest that the present interest in rehabilitation might profitably be translated into the following concrete proposals for the better treatment of neurosis.

Stage 1.

" Medical Rehabilitation." A need exists for the better psychiatric education of physicians and nurses so that neurosis may be prevented at the onset. There must also be more adequate facilities for treatment in the early stages. There must be a greater emphasis upon useful and purposive forms of occupational therapy adapted to the patient's needs. Occupational therapy at its best should always combine the sense of individual achievement with the sense of worth-while purpose.

Stage 2.

" Post-hospital Rehabilitation " or Convalescence. For certain patients a short period (e.g., up to four weeks) of " active " convalescence is needed, with emphasis upon a brisk invigorating psychological "atmosphere" and general physical "reconditioning" in a non-hospital environment. Such a centre need not be exclusively for psychoneurotic patients. For other patients a rather longer period of "reconditioning" should be arranged in an establishment designed to enable the patient to bridge the gap between a period of hospital treatment and a return to normal life. Costs at such an establishment should be kept at a minimum by arranging for patients to do most of the work.

Stage 3.

" Resettlement." A closer liaison between the physician, the Labour Exchanges and the Employers and Welfare Officers. The psychiatric social worker can play a large part in creating such liaison. Medical supervision of the patient at this stage must necessarily be very indirect.

4. *SPECIFIC SUGGESTIONS FOR THE CASSEL HOSPITAL.*

Obviously many of the views expressed in this report would require national rather than individual planning. There are, however, certain lines of development which might now or at some future date be considered by the Committee of the Cassel Hospital as lying within the boundary of practical possibility for the hospital itself.

At Stage 1.

It is suggested that there is at the present time considerable scope for the development of occupational therapy along the lines discussed in this report. With the approval of the Committee patients have undertaken many more and more varied domestic tasks than ever before. Under the guidance of the kitchen supervisor they have prepared meals for staff and patients, they have been responsible for most of the gardening and some cleaning, dusting, etc. Among patients suffering from neurosis many problems arise when activities of this type are

extensively undertaken. The administrative and nursing personnel need to have much patience and tact in their solution, but the results are often highly beneficial.

At Stage 2.

It is suggested that after the war, if circumstances permit, the Committee might consider the establishment of a special Convalescent Institution for psychoneurotic patients requiring a period of readjustment along the lines discussed in this report. Residence in such an establishment would probably have to be limited to (say) six months and periodical medical consultations should be arranged. The cost of maintenance would be low since much of the work could be done by resident patients. The establishment would have a beneficial effect on the work of the parent hospital by relieving the waiting list and reducing long periods of residence in it. The patient who has to stay more than 12 months in hospital is often unconsciously a bad influence on newcomers who tend to lose their sense of urgency and their ideas as to the possibility of a quick recovery.

At Stage 3.

After the war the Committee might consider the appointment of a psychiatric social worker who would undertake much of the detailed supervision of late-stage rehabilitation. She would also greatly assist in the study and amelioration of difficult environmental problems in the earlier stages of treatment. The geographical problem is the most difficult one in this connection.

MEDICAL WORK OF THE HOSPITAL DURING THE YEAR 1942.

The first eight months of 1942 may be regarded as a highly satisfactory period during which the improved efficiency of modern methods of treatment in the neuroses showed a visible effect upon our results. During this period the total discharge rate almost equalled that of the equivalent period in 1938 when double the number of beds and twice the medical staff were available.

This is an important point for the future, since one of the most serious problems in the successful treatment of neurosis is the provision of adequate medical staff and sufficient time.

Five doctors working in a whole-time capacity were only able to be responsible for a total of 143 discharges during 1938. Each doctor was then able to treat up to 14 patients at one time. The number of patients who can be adequately treated has now increased to about 16 per physician. This figure is very much lower than that accepted for E.M.S. Neurosis Centres, but it is necessary to bear in mind that our patients are carefully selected as being suitable for vigorous treatment; there are no chronic cases and no mentally-retarded patients who simply require placement.

The rate of our turnover during the period under review increased to such an extent that the number of discharges per physician per annum rose from under 30 to over 50. Immediate results, to judge from the tables, are quite as good as in previous years.

An important factor in achieving this increased output has been the use of electric shock therapy in the depressive states. Other measures of physical treatment have also been of value, notably the use of continuous narcosis for certain anxiety neuroses, insulin and glucose for disorders associated with marked physical debility and asthenia, and intravenous barbiturate narcosis to induce a state in which rapid psychological analysis is possible.

Other factors also played an important part. Ease of placement in employment after illness was of great assistance, as was also the keenness of patients to get well as quickly as possible in order to contribute their share to the war effort.

Finally, it must be admitted that the number of beds available in the hospital—from January to September the figure was 34—could not be compared very accurately with the number of beds available at Swaylands in peacetime—64 in 1938. A system was adopted of boarding out quite a number of convalescent patients in the neighbourhood and these came to the hospital for treatment from time to time. The system worked well, local residents accepted them as paying guests in some cases, and in others they lived in lodgings or hotels. They were able to do a day's work or follow some course of training whilst still under the wing of the hospital. Various sheltered employments were arranged for some of them, e.g., work in the local Citizens' Advice Bureau or at Day Nurseries as voluntary helpers. Others were able to begin to earn a living.

The success of this experiment augurs very well for the success of the type of convalescent home outlined in a section of this report.

Unfortunately, in September, the Medical Staff was compulsorily reduced and the scheme had largely to be suspended. Since then not only has it been impossible to continue to treat what were in effect out-patients, but the number of in-patients has also had to be reduced slightly. Accordingly the figures for the whole year of 1942 do not reflect accurately the improved rate of turnover.

In peacetime if it is possible to establish a suitable convalescent home our annual discharge rate should

increase considerably. As far as one is able to judge, with 64 beds available and an adequate medical staff, it should be possible for from 200 to 250 patients to pass through the hospital each year.

This larger total should add considerably to the scope and usefulness of the hospital and should serve to reduce the waiting list which has always been a bugbear. It would be most satisfactory if a position could be reached so that urgent cases of neurosis could be admitted immediately. At present this is seldom possible and there is often very considerable delay.

TABLES OF RESULTS.

The annual tables require little comment. The outstanding feature of Table 2, which shows classification by diagnosis, sex and condition on discharge, is a further slight rise in the proportion of depressions in the series. This rise was forecast last year. It is not great but, in our opinion, it reflects the increased incidence of a type of case which appears to be a typical feature of civilian practice in this war.

Cases of depression this year account for 37% of all our admissions, in 1942 they accounted for 30% and in 1938, the last year of peace, for 27%.

Long hours of work, lack of adequate recreation and misplaced conscientiousness have all played their part in producing this type of reaction in predisposed individuals. Fortunately such cases have responded well to treatment, either to rest and simple psychotherapy in their mildest examples, or to shock therapy in more resistant cases.

The results on discharge for the year are at least as good as for previous years and our follow-up data for patients discharged from 1938 onwards are again quite consistent. In the Annual Report for 1941 an analysis of the follow-up data then available was undertaken with a view to discovering any adverse effects which the war might be having upon this predisposed section of the population. With the exception of the forecast of a rise in the incidence of mild depressive reactions already noted, no such adverse effects were found. These observations are fully confirmed by the follow-up data presented this year.

Gloomy suggestions which have been made from time to time concerning the long-term effects of war strain upon the civilian are not substantiated by our findings, derived from that section of the population in which strain might be expected to show most readily.

SHOCK THERAPY.

Electrical shock therapy has continued to prove of inestimable value in the treatment of depressive states for which we now reserve it almost entirely. We have entirely abandoned its use for such schizophrenic reactions as have come under our care. In our opinion these patients should be given insulin therapy at the earliest opportunity and time spent on electrical shock therapy is valuable time wasted.

We have had no complications among female patients under shock therapy. A few male patients have complained of more or less severe pain in the back which has seldom been associated with radiological evidence of trauma. There has been no long-lasting disability from this cause. Recently we have instituted the plan first used in America of placing the patient upon a rigid mattress with a firm pillow or rolled-up blanket beneath his thoracic spine. Hyperextension is then applied by pressure upon the shoulders and, if necessary, the hips. The jaw is held firmly over a gag to prevent dislocation. With this method, complaints of pain and stiffness have been very greatly reduced and it is hoped that with improvement in our technique they may be almost completely eliminated.

1942.

TABLE 1.

TOTAL NUMBER OF PATIENTS DISCHARGED FROM HOSPITAL DURING 1942.

New Patients	*Re-admissions*	*Total*	*Discharged unsuitable within one month*	*Total in which treatment undertaken*
98	11	109	7	102

TABLE 2.

TOTAL NUMBER OF PATIENTS FOR WHOM TREATMENT WAS UNDERTAKEN DURING 1942.
CLASSIFICATION BY DIAGNOSIS, SEX AND CONDITION ON DISCHARGE.

Diagnosis	MALES				FEMALES				TOTALS			
	Much Imp.	*Imp.*	*Not Imp.*	*Total*	*Much Imp.*	*Imp.*	*Not Imp.*	*Total*	*Much Imp.*	*Imp.*	*Not Imp.*	*Total*
Anxiety States	8	2	1	11	8	8	2	18	16	10	3	29
Hysteria	1	1	—	2	3	2	3	8	4	3	3	10
Anorexia Nervosa	—	—	—	—	—	—	2	2	—	—	2	2
Obsessional States	—	—	—	—	—	1	—	1	—	1	—	1
Alcoholic State and Drug Addiction	1	—	—	1	1	2	—	3	2	2	—	4
Depressive States	11	3	2	16	15	3	4	22	26	6	6	38
Organic and Toxic States ...	—	—	—	—	—	1	—	1	—	1	—	1
Psychopathic Personality ...	—	2	3	5	1	2	—	3	1	4	3	8
Paranoid States	1	—	—	1	—	2	—	2	1	2	—	3
Unclassified Neuroses ...	2	—	1	3	2	—	—	2	4	—	1	5
Excitement	—	—	—	—	1	—	—	1	1	—	—	1
Total	24	8	7	39	31	21	11	63	55	29	18	102
Percentage	62%	20%	18%	100%	49%	34%	17%	100%	54%	28%	18%	100%

TABLE 3.

PERCENTAGE DISTRIBUTION OF RESULTS ON DISCHARGE AND AT FOLLOW-UP.

CASES DISCHARGED DURING 1938.

Condition	*On Discharge*	*Follow-up*			
		1939	1940	1941	1942
Much improved ...	58	45	54	60	52
Improved	24	28	18	15	16
Not Improved ...	18	27	28	25	32
Total	100	100	100	100	100
Total cases in which percentage based...	120	79	65	60	44
Number not replying to follow-up ...	—	41	55	60	76

CASES DISCHARGED DURING 1939.

Condition	*On Discharge*	*Follow-up*		
		1940	1941	1942
Much Improved ...	48	43	52	52
Improved	32	20	20	22
Not Improved ...	20	37	28	26
Total	100	100	100	100
Total cases on which percentage based...	146	94	71	46
Number not replying to follow-up ...	—	53	75	100

CASES DISCHARGED DURING 1940.

Condition	*On Discharge*	*Follow-up*	
		1941	1942
Much Improved	42	44	49
Improved	40	27	24
Not Improved	18	29	27
Total	100	100	100
Total cases on which percentage based	130	68	66
Number not replying to follow-up	—	63	64

CASES DISCHARGED DURING 1941

Condition	*On Discharge*	*Follow-up* 1942
Much Improved	52	54
Improved	34	19
Not Improved	14	27
Total	100	100
Total cases on which percentages based	85	59
Number not replying to follow-up ...	—	26

REPORT OF THE GENERAL COMMITTEE.

GENERAL.—The Committee are glad to be able to report that in November Mr. S. W. Smart, who for some time had taken a great interest in the affairs of the hospital and rendered considerable assistance, became a Member of the General Committee of the hospital.

The medical establishment of the hospital was reduced by the Central Medical War Committee from the 1st September notwithstanding representations by the Chairman of the Hospital and the Chairman of the Medical Committee. Since that time the medical staff of the hospital has consisted of the Medical Director and one Assistant Physician. Dr. Maurice Rayner entered the Army in September as a specialist in psychiatry. This reduction in medical staff unfortunately necessitated a reduction in the total number of patients under treatment. The number of beds available was reduced from 34 to 31 and the number of patients seen after discharge as out-patients had to be reduced.

Regular lectures for the nursing staff have been delivered by the medical staff throughout the year, and a hospital certificate is issued to those trained nurses who have completed a year at the hospital and have satisfied the required standards.

In April a lecture was delivered by the Medical Director, Dr. C. H. Rogerson, on "Psychological Factors in Disease," when a meeting of the North Staffordshire branch of the Royal College of Nursing was held at Ash Hall. Other visitors at this meeting were head mistresses of schools in the district, representatives of the Chartered Society of Massage and of the Society of Occupational Therapists.

Sir Farquhar Buzzard, the Chairman of the Medical Committee, visited Ash Hall in October. On the occasion of his visit Sir Farquhar lectured in the district at the annual meeting of the North Staffordshire branch of the Royal College of Nursing, and the Staff at Ash Hall had the privilege of entertaining and discussing nursing problems with several prominent members of the nursing profession.

During the year the Matron, Miss F. A. Rowe, delivered a series of lectures in London to various divisions of the British Red Cross Society upon "Psychological Factors in Nursing."

In November the hospital adopted the Federated Superannuation Scheme for Nurses and Hospital Officers and the majority of the staff at Ash Hall are now members.

OCCUPATIONAL THERAPY DEPARTMENT, LIBRARY, ENTERTAINMENTS, ETC.

Occupational Therapist.—Miss M. DAWSON.

In Charge of Library, "Keep Fit" Classes and Country Dancing.—Miss M. STILES.

In Charge of Gardening Teams.—Mr. G. SNAPE.

Occupational Therapy. — During 1942 the patients' occupations, both in and beyond the occupational therapy department, have been more varied than the previous year. In addition to the usual craftwork several patients have been usefully occupied at a neighbouring farm, where they gave some assistance with the work of harvesting, hoeing, etc. A few have helped at one or other of the Nursery Schools in this locality. Some have made use of the commercial courses in shorthand, typing, etc., offered in the neighbourhood, while one patient attended the School of Art at Burslem for weekly lessons in life drawing. There are always some patients to whom domestic types of occupation give the greatest satisfaction, and these have undertaken such duties as the laying of tables, bed-making, cooking, etc., while amongst the men gardening, wood cutting and the care of the tennis court and lawn have provided scope for more strenuous work.

Of the workshop handicrafts which form the first step for many of the more ill patients, weaving and leatherwork interested the largest number, possibly because these crafts give plenty of scope for individual taste, while often forming a wholly new field of interest. The sense of achievement seen in patients finishing work of these kinds is very noticeable. A point for the Occupational Therapist is that materials for these crafts were still "in good supply." Book-binding was carried on by a smaller number of patients, usually those who gave assistance as librarians. A fairly wide variety of other crafts was also carried on, including modelling, stool-seating, glove-making, cord-knotting, carpentering, etc., and many patients found their lost interest returning to them as they learned one or other of these, while further stimulus is provided incidentally when patients see what their fellows are doing.

In October Miss Dawson gave a lecture at Ash Hall on Occupational Therapy to members of the local Midwives Board. She has also given elementary instruction in Occupational Therapy to Red Cross Students in the neighbourhood.

During the past year a Red Cross Student has received the privilege of three months' training in Occupational Therapy in return for some nursing and general assistance in the hospital.

The Cassel Hospital has now been approved for the practical part of the training for the Diploma in Occupational Therapy. Students are at present accepted for three months' training.

The training of these students forms a valuable link with other hospitals and with schools of Occupational Therapy over a wide field.

The increased activities in the department of Occupational Therapy have been made possible by the conversion of a hut in the grounds for the purposes of carpentering and certain other crafts.

Entertainments.—The evening entertainments, organised by the patients' Entertainments Committee, have been carried on as in other years, with one special effort, a short play, which was produced as the chief item in a programme of recitations, songs and piano solos.

Library.—The Library has been much used by both Patients and Staff, and to show their appreciation several patients on their departure have presented books. The patients take a large share in the running of the Library, a complete new catalogue has been prepared by them, and many disused books turned out and sent to the Forces.

Cinema.—Cinematograph shows have been given every week during the winter months, the programmes alternating between documentary films, obtained free from various educational centres, and feature films, to which latter the hospital's many friends in the vicinity have been invited.

" Keep Fit " and Country Dancing.—The bi-weekly " Keep Fit " classes for women patients are still being held and prove a great help in many stages of treatment, especially in the matter of relaxation and self-expression. As a stimulus to concentration, weekly Country Dancing classes are held and are immensely popular with both patients and staff.

Outside Activities.—Several parties of patients have enjoyed visits to Messrs. Copeland's Spode Works in Stoke, where all processes of potting are seen in succession, ending with a tour of their famous show room. The Wedgwood model factory has also been visited on two occasions with keen interest. During the short spells of summer weather one or two supper picnics were arranged, and a few patients have enjoyed outings by bicycle, soon discovering the attractions of this countryside.

Altogether between prescribed occupations and chosen recreations it has been possible to create and stimulate a widely varied range of interests.

SWAYLANDS GARDENS.—Regular weekly supplies of vegetables and fruit are sent to Ash Hall from Swaylands through the kind assistance of the Southern Railway.

Considerable alterations have been carried out in the market gardens at Swaylands to enable the most efficient production of vegetables to be achieved. Several old poultry houses have been dismantled and the remaining houses re-grouped so as to make available a maximum area for cultivation. The Kent War Agricultural Committee have expressed their approval of the work done. A horse was purchased for seventy guineas as, owing to the increased area under cultivation, it was felt that the use of a horse for row-crop and other work would best supplement the existing Fordson tractor. The Committee desire to place on record their appreciation of the excellent work done by the Head Gardener and his staff.

FINANCE.—The Income of the hospital from all sources has again proved sufficient to meet both Ordinary and Extraordinary Expenditure, and a surplus is shown on the year's working of £3,448. The corresponding figure for the previous year was £3,878. It has to be remembered that the surplus on the working of the hospital during the past two years arises from exceptional circumstances and is directly attributable to (*a*) the unavoidable curtailment of the hospital's activities following the requisition in 1940 of the Freehold Buildings and Land donated by the Founder, and (*b*) the Rents Receivable from the requisitioned properties which are more than sufficient to offset the charges and outgoings of the temporary premises now occupied by the hospital at Ash Hall. This surplus and profits realised on the sale of investments should help to meet the costs incurred in moving from Swaylands to Ash Hall and costs of moving back and re-adapting Swaylands after the war.

The Trustees have adhered to the policy of investing the Surplus Funds in Government Securities, and the Surplus Income for the past year, together with the proceeds of Investments requisitioned or redeemed, have been invested for the greater part in 3% Savings Bonds. Notwithstanding the redemption of certain Securities—upon which a profit of £9,770 was realised and added to the Founder's Trust Fund—the market value of Investments at 31st December, 1942, exceeded the Book Value (or Cost) by approximately £7,200.

The inclusive average weekly cost per patient for the year amounted to £8 12s. 6d., which was practically identical with that of the previous year.

The fees remain at four to five guineas per week for those sharing a room and from six to ten guineas per week for those in single rooms. The fees are inclusive of everything except costly drugs not ordinarily dispensed in the hospital. The fees are fixed according to the means of the patient and not according to the type of room available. The average fee was £5 13s. per week. In certain cases it is possible to reduce these fees by donation from the Medical Director's Special Fund, which is made up of bequests to the hospital and fees from out-patients, and is available for this purpose. Occasional assistance in needy cases has been obtained from a charitable fund, the trustees of which desire to remain anonymous. This fund has proved a very valuable help to several patients.

Towards the close of the year the Trustees received a bequest under the Will of the late Miss Mary Ann Oake amounting to £597 19s. 6d. In compliance with the deceased's wishes the Income from this bequest will be applied in the same way as the Medical Director's Special Fund for assisting necessitous patients.

The Committee desire to place on record how much the hospital is indebted to the entire staff for the constant care and zeal and the ability they have shown in the discharge of their duties under very difficult circumstances.

By Order of the General Committee,

FELIX CASSEL.

Chairman

THE CASSEL HOSPITAL FOR FUNCTIONAL NERVOUS DISORDERS.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31st DECEMBER, 1942.

INCOME.

	£ s. d.	£ s. d.
Ordinary—		
I. Receipts on Account of Services Rendered.		
(*a*) From Patients—Fees		9,377 0 8
(*b*) State Grant—Nursing Salaries ...		62 1 8
II. Invested Property. Interest, Dividends, etc. ...		4,992 16 0
Ordinary Income ..		14,431 18 4
Extraordinary—		
I. Rents of Evacuated Properties ...	2,915 9 7	
II. Surplus on Swaylands Gardens ...	349 10 3	
Extraordinary Income		3,264 19 10
TOTAL INCOME ...		17,696 18 2
		£17,696 18 2

EXPENDITURE.

	£ s. d.	£ s. d.
Ordinary—		
I. Provisions		2,347 11 1
II. Surgery and Dispensary		211 5 8
III. Domestic		1,481 2 1
IV. Salaries and Wages (Maintenance)		6,750 17 7
V. Miscellaneous		854 6 6
VI. Administration		948 11 11
VII. Establishment		60 5 5
VIII. Finance		1,039 11 11
Ordinary Expenditure		13,693 12 2
Extraordinary—		
I. Upkeep of Evacuated Properties (including War Damage Insurance)	459 0 3	
II. Alterations and Decorations—Ash Hall	96 12 5	
Extraordinary Expenditure		555 12 8
TOTAL EXPENDITURE		14,249 4 10
Balance, being excess of Total Income over Total Expenditure for the year		3,447 13 4
		£17,696 18 2

BALANCE SHEET, 31st DECEMBER, 1942.

	£ s. d.	£ s. d.	£ s. d.
Creditors—			
Tradesmen's Accounts and Accrued Expenses			1,679 17 9
Capital Accounts—			
(*a*) Founder's Trust Fund as at 31st December, 1941		211,065 5 4	
Add : Profit on Realisations of Investments (net)		9,770 17 3	
		220,836 2 7	
(*b*) Special Funds—			
THE KATHARINE WALEY COHEN TRUST FUND—gift for special purposes	1,582 1 6		
THE H.G.K. TRUST FUND—gift for special purposes	500 0 0		
THE BERNARD TEMPLE WRINCH SETTLEMENT—bequest for general purposes	7,782 13 0		
THE MARY ANN OAKE BEQUEST—gift for special purposes ...	597 19 6		
		10,462 14 0	
(*c*) General Fund as at 31st December, 1941 ...	17,499 9 4		
Add : Excess of Income over Expenditure for the year ended 31st December, 1942, per annexed Account ...	3,447 13 4		
		20,947 2 8	
			252,245 19 3
Unexpended Income Balance of Special Fund—			
Medical Director's Special Fund as at 31st December, 1941		78 3 1	
Add Interest and Donations for year		167 1 11	
		245 5 0	
Less Grants during year		115 4 2	
			130 0 10
			£254,055 17 10

	£ s. d.	£ s. d.	£ s. d.
Cash at Bank and in Hand—			
On Account of—			
(1) General Fund ...		2,809 17 10	
(2) Medical Director's Special Fund ...		130 0 10	
(3) The Mary Ann Oake Bequest ...		137 19 6	
			3,077 18 2
Stocks on Hand			550 11 8
Debtors and Payments in Advance			557 0 4
Interest Accrued on Investments			1,782 9 5
Investments at Cost—			
(*a*) Founder's Trust Fund ...		113,955 11 11	
(*b*) Special Funds—			
THE KATHARINE WALEY COHEN TRUST FUND ...	1,582 1 6		
THE H.G.K. TRUST FUND	500 0 0		
THE BERNARD TEMPLE WRINCH SETTLEMENT	7,782 13 0		
THE MARY ANN OAKE BEQUEST	460 0 0		
		10,324 14 6	
(*c*) General Fund ... ... (*Market Value* £148,416 18 5)		16,927 1 2	
			141,207 7 7
Land, Buildings and Equipment—			
As at 31st December, 1941 ...			106,880 10 8
			£254,055 17 10

NOTE—A Claim for compensation is pending in respect of damage sustained by enemy action.

We have audited the above Balance Sheet dated 31st December, 1942, and have obtained all the information and explanations we have required. In our opinion such Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of affairs, according to the best of our information and the explanations given to us and as shown by the books of the Hospital.

ALDERMAN'S HOUSE, BISHOPSGATE,
LONDON, E.C.2.
30*th April*, 1943.

BARTON, MAYHEW & Co.,
Chartered Accountants.

INVESTMENTS AT COST—AS AT 31st DECEMBER, 1942.

	£ s. d.	£ s. d.
(a) **Founders' Trust Fund**—		
£9,970/5/11 3½% War Loan	9,837 8 3	
£15,500 Local Loans 3% Stock	12,702 9 6	
£10,000 Birmingham Corporation 4¾% Redeemable Stock, 1945/55 ...	9,853 15 0	
£5,796/9/7 Commonwealth of Australia 5% Registered Stock, 1945/75	5,711 13 8	
£6,413/19/6 Consolidated 4% Stock	6,393 12 9	
£7,200 London & North Eastern Railway 4% 1st Preference Stock ...	4,973 8 9	
£3,237/13/6 3½% Conversion Loan, 1961	2,476 19 7	
£500 London Transport 5% "A" Stock	496 18 0	
£3,100 Bass Ratcliff & Gretton Ltd., 3½% "B" Mortgage Debenture Stock	3,153 14 9	
£3,000 Barclay Perkins & Co., Ltd., 3½% Mortgage Debenture Stock	3,020 0 3	
£1,500 Bristol Corporation 3% Loan 1958/63	1,491 12 3	
£1,150 South Suburban Gas Co., 5% Perpetual Debenture Stock ...	1,273 0 10	
£2,000 London Transport 5% "B" Stock	2,279 11 0	
£8,900 3% Saving Bonds 1955/65	8,900 0 0	
£368 William Younger & Co. Ltd. 3½% Debenture Stock	333 18 4	
£620 Great Indian Peninsular Railway 4% Irredeemable Debenture Stock	636 3 8	
£900 3% Defence Bonds P.O. 3rd Issue	900 0 0	
£2,000 2½% National War Bonds 1945/47	2,021 5 4	
£32,500 3% Savings Bonds 1955/65 "B"	32,500 0 0	
£5000 3% Savings Bonds 1960/70 "A"	5,000 0 0	
(*Market Value* £118,818 7 5)		113,955 11 11
(b) **Special Funds**—		
THE KATHARINE WALEY COHEN TRUST FUND—		
£1,665 "Shell" Transport & Trading Co., Limited, 5% 1st Preference Stock. Fully paid (*Market Value* £2,122 17 6)	1,582 1 6	
THE H.G.K. TRUST FUND—		
£496/4/6 3½% War Loan at cost (*Market Value* £521 0 9)	500 0 0	
THE BERNARD TEMPLE WRINCH SETTLEMENT—		
£7,807/6/0 Consolidated 4% Stock (*Market Value* £8,627 1 4)	7,782 13 0	
THE MARY ANN OAKE BEQUEST—		
£100 3% Defence Bonds. P.O. Issue ... 100 0 0		
£356/0/6 3½% War Loan 360 0 0		
£250 Textile Trades Corporation Berlin 7% Stock Trust Certificates		
(*Market Value* £473 16 6)	460 0 0	
		10,324 14 6
(c) **General Fund**—		
£14,314 Irish Free State 4½% Land Bonds	15,802 11 5	
£809 Consolidated 4% Stock	806 11 3	
£335 "Shell" Transport and Trading Co., Ltd., 5% 1st Preference Stock. Fully paid	317 18 6	
(*Market Value* £17,853 14 11)		
		16,927 1 2
		£141,207 7 7

STATISTICAL TABLES FOR THE YEAR ENDED 31st DECEMBER, 1942 and comparison with the Year ended 31st December, 1941.

ACCOMMODATION.	1942	1941	
Number of available beds	33*	33	*(Reduced to 31 as from 15th Dec., 1942.)
Average number of patients resident daily	31.69	30.72	
Number of admissions during the year	109	96	
Number of discharges during the year	111	90	
Number remaining at 31st December	30	32	

EXPENDITURE.	Expenditure for the year ended 31st Dec., 1942.	Average weekly cost per patient during 1942.	Average weekly cost per patient during 1941.
ORDINARY.	£ s. d.	£ s. d.	£ s. d.
Provisions	2,347 11 1	1 8 5	1 8 8
Surgery and Dispensary	211 5 8	2 7	3 2
Domestic	1,481 2 1	17 11	14 6
Salaries and Wages	6,750 17 7	4 1 8	3 16 11
Miscellaneous	854 6 6	10 4	6 10
Administration	948 11 11	11 6	16 11
Establishment	60 5 5	9	1 3
Finance	1,039 11 11	12 7	11 9
	13,693 12 2	8 5 9	8 0 0
EXTRAORDINARY.	555 12 8	6 9	12 8
Total Cost ...	£14,249 4 10	£8 12 6	£8 12 8

Wm. Hodge & Chilver, Ltd., 86, Hatton Garden, London, E.C