The Bethlem Royal Hospital and the Maudsley Hospital : triennial statistical report : years 1949-1951 / by C.P. Blacker, A.T. Gore.

THE BETHLEM ROYAL HOSPITAL
AND THE MAUDSLEY HOSPITAL

TRIENNIAL STATISTICAL REPORT

YEARS 1949-1951

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C. P. BLACKER · A. T. GORE

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PREFACE

In July 1948, the Bethlem Royal Hospital and the Maudsley Hospital, which had previously been independent of each other, were combined as a Teaching Hospital. This report covers the activity of the Joint Hospital from 1st January, 1949 to 31st December, 1951.

It has been prepared by Dr. C. P. Blacker, a Consultant-Physician of the Hospital, and Mr. A. T. Gore, Statistical Assistant, Public Health Department, the London County Council. The Hospital is deeply indebted to the London County Council for the statistical assistance which it has provided in recording and analysing the data.

The thoroughness of the records is in large measure the outcome of the detailed attention Dr. Blacker has given to their collection, and the Hospital is fortunate in being able to avail itself of the experience he gained in carrying out ten years ago for the Ministry of Health a national survey of psychiatric facilities.

Dr. Blacker and Mr. Gore have prepared this report at the request of the Board of Governors, and are primarily responsible for its contents. The Governors intend that it should be the first of a series of triennial statistical reports. They hope that the findings, though necessarily derived from a special and selected population, will be of general interest.

MARY ORMEROD,
(Chairman of the Board of Governors)

AUBREY LEWIS,
(Professor of Psychiatry, Institute of Psychiatry, Maudsley Hospital)

June, 1955.

AUTHORS' FOREWORD

We wish to make it clear that this booklet is not to be taken as a conventional hospital report such as normally includes particulars about medical and non-medical staff, administrative matters and finance.

As explained in chapter one, the report's subject matter is the statistical information which, as a routine, is recorded on the front page of the case-notes of every out- and inpatient. No account is here given of the research projects which have been pursued in the hospital during the triennium. These activities are set out in the annual reports of the Institute of Psychiatry, a part of London University, which is accommodated in the Maudsley Hospital and to which most of the members of the Joint Hospital's senior staff are attached in the capacity of clinical teachers.

Nor does this report deal with an important source of additional statistical information assembled for all inpatients of the Joint Hospital: this is an item sheet recording some 400 particulars of social, clinical and psychological interest.

An explanation is due of the long period which has elapsed between the end of the triennium (31 December, 1951) and the date of publication. This report is the first of its kind and is, in a sense, a pioneer venture the attendant difficulties of which took time to solve. The delay is regretted. We well recognize that the value of a report such as this diminishes when publication is long postponed. Later reports in this series will, we hope, be more quickly prepared and published.

We are indebted to many people for help in the preparation of this Report. Our thanks are especially due to the following: Dr. Vera Norris, lecturer in medical statistics, Institute of Psychiatry; Professor Aubrey Lewis and Sir Allen Daley, members of the Governing Body of the Joint Hospital; Dr. B. Benjamin of the General Register Office (formerly Statistician to the London County Council); doctors B. Ackner, Kenneth Cameron, D. L. Davies, J. G. Hamilton, A. Harris and E. Stengel members of the Joint Hospital's Consultant staff; Mr. K. J. Johnson, the Joint Hospital's House Governor; Miss S. E. Hague, Secretary of the Institute of Psychiatry; Mrs. J. A. Stitson, Records Officer; Mrs. D. Perkins, Transcription Officer during the period covered by the triennium; and Mr. W. H. Duce, Senior Administrative Assistant at the Joint Hospital.

We are also specially indebted to Mr. W. Hope-Jones who has given valued assistance with the calculations.

We have tried to express ourselves throughout in simple language; and in commentaries on the tables we have drawn attention to what we regard as their noteworthy features.

C. P. BLACKER.

A. T. GORE.

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TABLE 1. BASIC FIGURES.: TRIENNIUM 1949-51

	Males	Females	Totals
A. ADULTS.			
1. *Individual Patients.*			
Total	3,857	3,930	7,787
Inpatients	1,171	1,465	2,636
Outpatients	2,686	2,465	5,151
Patients married	2,294	2,590	4,884
2. *Discharges (sometimes multiple for the same patient).*			
Total: In- and Outpatients combined	4,233	4,492	8,725
Inpatients	1,397	1,848	* 3,245
Outpatients not warded ...	2,836	2,644	5,480
Outpatients warded and included in figure for Inpatients	958	1,275	2,233
Total Outpatient Discharges	3,794	3,919	7,713
B. CHILDREN.			
1. *Individual Patients.*			
Total	747	464	1,211
Inpatients	153	97	250
Outpatients	594	367	961
2. *Discharges (sometimes multiple for the same patient).*			
Total: In- and Outpatients combined	780	489	1,269
Inpatients	170	114	284
Outpatients not warded ...	610	375	985
Outpatients warded and included in figure for Inpatients	74	67	141
Total Outpatient Discharges	684	442	1,126

* 1,437 Inpatients Bethlem Royal Hospital.
1,808 Inpatients Maudsley Hospital.

THE BETHLEM ROYAL HOSPITAL AND THE MAUDSLEY HOSPITAL

First Triennial Report 1949-51

CHAPTER ONE

INTRODUCTION.

1. Formation of Joint Hospital.

Before the year 1948, the Bethlem Royal Hospital and the Maudsley Hospital each had traditions, customs and administrative arrangements of its own. In July of that year, the two hospitals combined. When in the ensuing months a common pattern was being worked out, the records system claimed immediate attention.

The two hospitals are some nine miles apart and perform different functions. The most important differences are that the Maudsley had an active outpatient department while Bethlem had none, and that the Maudsley contained a large children's department whereas Bethlem did not deal with children. These differences remain today, though Bethlem now contains a unit for adolescents.

A records system was therefore required which would both take account of the differing activities of the two hospitals and also allow for such future expansions—development of domiciliary services, establishment with Guy's Hospital of a joint Neurosurgical Unit, etc.—as would be demanded by the country's developing health services. Adjustments were further called for by the close association of the Joint Hospital with the Institute of Psychiatry of the University of London.

2. The Joint Hospital's Debt to the London County Coucil.

An ideal records system should satisfy two requirements. It should first enable the registry clerk or records officer to pick out, within a matter of seconds, a set of case-notes from files which contain thousands; and second it should make easy the compilation of statistical information about the hospital's activities. These two requirements are met if the information required for statistical purposes is transcribed and recorded on punched cards. This system was first adopted over an eleven months trial period in the year 1948. The Statistical Section of the Public Health Department of the London County Council, of which Dr. B Benjamin was then the director, most kindly performed the punching and sorting. This they continued to do in the ensuing three years which are covered in this first triennial report. The Joint

Hospital owes a debt of gratitude to the London County Council for its help in the preparation of this report, and especially to the staff of the statistical machine room who so carefully compiled the punched cards and prepared the tabulations for this report. The London County Council, however, is in no sense whatever responsible for this report.

3. A Triennial Report.

Information required for statistical purposes should be recorded on the front page of the case-notes. Much thought and experiment is needed before a front page is finally standardised. The "front page problem" had been under active consideration from the year 1946 at the Maudsley hospital when it re-opened after the war. A front-page which had been in use for many years when the hospital was under the control of the London County Council was then discarded and in the course of 1947 changes, both in substance and arrangement, were tried out. The eleven months' trial run above mentioned covered the period 1 February—31 December, 1948, the year in which the Bethlem and Maudsley hospitals combined. The front page was thereafter slightly modified, and a Records Handbook, explaining the use of the front page, was produced.

Many useful lessons were learned from this trial run, one being that the figures covering a single year would, from a statistical standpoint, be rather small. It was therefore decided to produce a consolidated triennial report covering the three years 1949-1951, and, if the experiment were deemed successful, to prepare subsequent triennial reports based on periodic revisions of the front page. These would be designed to bring out new features of the Joint Hospital's activities. Another reason for postponement was the fact that, after 1951, the results of that year's census would be available. Norms would be provided with which our figures could be compared.

Most of the tables, which were prepared to our specification, are large and unwieldy, and consequently unsuitable for publication in full in a report of this character. In the following pages, therefore, the salient features only are shown in condensed form. The full tables, which are kept at the Maudsley hospital, can be seen by interested persons who are duly authorised.

It should be repeated that the information contained in this report does not cover the whole of the statistical material assembled at the Joint Hospital. A further source is provided by an *item sheet*, comprising over 400 items, which records detailed social, clinical and psychological particulars about all *inpatients*. The analysis of this extensive material is necessarily carried out on different lines from that of the information supplied by the front page of the case notes on which this report is based.

4. Character of Joint Hospital's Patient Population: Inpatients.

The status of the Joint Hospital as a post-graduate teaching body and its association, through the Institute of Psychiatry, with the University of London, combine to give it somewhat unique features. These affect the selection of inpatients and also, to a much lesser extent, of outpatients. These are separately considered.

The following factors jointly influence the selection of inpatients.

(1) The hospital admits no certified patients. All inpatients must come in of their own free will and can discharge themselves when they wish. During the triennium the Joint Hospital contained no private or amenity beds.

(2) Henry Maudsley, whom we revere as the founder of the hospital which bears his name, attached certain conditions to his foundation bequest, among them that the hospital should primarily deal with early and remediable cases. These may be acute and certifiable though uncertified. Many such acute cases do well and recover quickly. They are essential for teaching purposes.

(3) The Joint Hospital takes in cases which have teaching interest. The junior staff of the hospital need to see as wide a variety as possible of clinical material in order to become acquainted, in the course of their training, with all diagnostic and therapeutic methods.

(4) The hospital has certain special activities. It has a Child Psychiatric Clinic to which children are referred. It has a Geriatric and Adolescent unit, and also a unit for the treatment of the Epilepsies. In the Maudsley's grounds is a Neurosurgical unit which is shared with Guy's Hospital. These special units and departments influence the type of patient which is admitted to the wards.

(5) Research projects are conducted in the hospital, and are largely though by no means exclusively connected with the Professorial Unit of the Institute of Psychiatry. Certain patients may be admitted, and sometimes retained in hospital for longer than the customary period, because of their interest for special research projects.

(6) The hospital co-operates with other teaching hospitals and with consultants throughout the country. Beds outside mental hospitals for psychiatric cases are nowhere plentiful and appropriate disposal of voluntary patients is not easy. The Joint Hospital tries to co-operate with other hospitals and outside consultants in meeting requests for admissions.

(7) The hospital provides a service for local general practitioners, especially for those in South London, Kent and Surrey. The Maudsley hospital is situated on the boundary between Camberwell and Lambeth and receives many outpatients from

doctors practising in these two Boroughs. It has sought to establish friendly contact with these doctors who, in 1950, were invited to a reception which was well attended. The Medical committee regards it as especially important that the Maudsley hospital (which, unlike Bethlem, receives outpatients) should have a good local reputation and be favourably regarded by local practitioners and population. Links with local practitioners have, since 1950, been further established by the provision of a domiciliary service in which one member of the medical staff (Dr. Denis Leigh) has taken a special interest. Domiciliary visits have provided, since they were begun in 1949, a regular quota of admissions to the wards.

(8) The type of patient admitted to the Joint Hospital is affected, as are admissions to all other psychiatric units which deal with voluntary patients, by a desire to preserve standards in particular wards. The reputation of a hospital in the outside world depends not only on the amenities it provides and on the qualities of its medical and nursing staff; it also depends on the behaviour and demeanour of the patients. A ward which contained for more than short periods an excess of psychopaths of low intelligence and dirty habits, or of thieves who stole the property of other patients, would quickly acquire a bad reputation. It will be seen below that more of the Joint Hospital's inpatients than outpatients belonged to the Registrar General's classes 1 and 2, and fewer to his classes 4 and 5. This distribution is not the result of a single factor. Several of those considered above have contributed.

(9) Last but by no means least of the considerations which influence admission is the interests of the patients themselves, and of their relatives. These interests are, in a collective sense, best served if the intentions which Henry Maudsley had in mind for the hospital are observed—that is to say if priority is given to early and remediable cases.

5. Character of Joint Hosptial's Patient Population: Outpatients.

Whereas the consent of a member of the senior medical staff is necessary before an inpatient is admitted to a ward, so that the ward population is entirely controlled by the hospital's medical staff, little selection is applied to outpatients. Though a few of these are booked by the consultants themselves, and some are ex-inpatients referred after discharge to the outpatient department, the majority are sent by general practitioners many of whom practise locally. These either book their patients ahead with the appointments clerk (the usual practice), or else send them up as emergencies who, during the triennium, were seen by a senior registrar specially concerned with the outpatient department.

Hence the Maudsley's outpatients should provide a fair sample of the type of case which is referred for psychiatric reasons by London general practitioners to a psychiatric unit. The features of the

sample will largely reflect the features of the district in which the patients live. The Maudsley hospital is situated on the boundary between the South London metropolitan boroughs of Lambeth and Camberwell; these are mainly inhabited by the Registrar-General's classes 3 and 4 which roughly comprise the lower middle classes. It will be seen from chapter 6 that about eighty per cent of Maudsley outpatients referred to the hospital by London general practitioners live in the south-eastern and south-western postal districts of London. Among our male patients (table 17) metal manufacture, engineering, transport and communications, clerical work and unskilled work provide the main occupations; and among our female patients, who are not housewives, clerical work and personal services (as domestics, waitresses, etc.) figure prominently. The occupational distribution of our patients accords fairly well with that for Greater London in 1951.

Nevertheless it is possible that a factor which is not immediately apparent to us may affect our sample of outpatients though perhaps not in such a way as to make it unrepresentative of Greater London.

Though the Maudsley hospital is not a mental hospital which takes in certified cases, it largely deals with patients who suffer from ailments which are commonly known as "nervous" and "mental". Hence the fact that a patient is attending or has attended the Maudsley hospital discloses the general nature of his illness. All the well-known London teaching hospitals have departments of psychiatry or of psychological medicine which deal with such patients. But it is easy for a patient to avoid disclosing which department of these hospitals he has been attending.

Table 84 on page 104 shows that, of the doctors practising in South East and South West London, less than a third referred patients to the Joint Hospital during the triennium. How are we to interpret this fact? It may mean that many doctors are uninterested in psychiatry and sceptical of the benefits which it can confer. Such would send few patients to psychiatric hospitals or to psychiatric departments of hospitals. On the other hand, it is possible that these doctors have established harmonious relations with the psychiatric departments of Guy's and Kings College Hospitals, which are in south London, or with other hospitals elsewhere, to which they habitually refer all their psychiatric patients. The first possibility—that some doctors have little faith in psychiatry and make no use of specialist services—is strongly suggested by the fact that a survey conducted in a midland city during 1942 and 1943 showed that only ten per cent of doctors practising in that city had, during those two years, ever referred patients to any of that city's psychiatric clinics. But this position, which was easily investigated in a midland city served by two or three psychiatric units and by a manageable number of practitioners, would be formidably difficult to clarify in Greater London. Our own figures are compatible with

the view that the Maudsley outpatients' department is freely used by a minority only of doctors practising within a five mile radius, but that these doctors are satisfied with the services the hospital provides and that they have little difficulty in persuading their patients that it is worth their while to attend a specialised hospital. Nor is there anything to suggest that the doctors who send us patients are not a representative sample of doctors practising in south London, or that the patients they send are not a representative sample of the London population. A small proportion of outpatients (under 20 per cent: Table 82) are referred by doctors practising north of the river and by specialists in the Harley Street area. These commonly make use of the Joint Hospital because of its inpatient facilities. They want their patients admitted.

6. Diagnosis: The International Classification.

Immediately after the war, the Maudsley hospital made use of a diagnostic list drawn up by the late Dr. Eric Guttmann which was based on the list used at the hospital's foundation. But in 1948 a change was made to the *International Classification of Diseases and Causes of Death* produced in 1947 by the World Health Organisation. This list is ingeniously devised to serve several purposes. It comprises over a thousand rubrics or numbered diagnostic groups, each of which may be subdivided by decimal points. These thousand groups are further divided into seventeen comprehensive sections of which the fifth, reproduced in the Appendix, covers *Mental, Psychoneurotic and Personality Disorders*. This section was used during the triennium. It was made available to the hospital's medical staff in the *Records Handbook* above-mentioned, of which a first edition was produced in 1948.

It is notorious that diagnosis in psychiatry presents such special and peculiar difficulties that no diagnostic list would satisfy everybody. The international classification, which, like every other classification is open to criticism, has presented certain problems which bear on the tables shown in Chapter 4 and which will here be briefly discussed.

It will be seen (Appendix) that section 5 of the International Classification comprises twenty-six diagnostic groups many of which are subdivided by decimals. These twenty-six groups are drawn up in three over-riding assortments as follows:

Psychoses (300-309)

Psychoneurotic Disorders (310-318)

Disorders of Character, Behaviour and Intelligence (320-326).

This tripartite arrangement is in some ways convenient; it is reproduced in tables 35 and 37 below. But it also presents difficulties. Thus it is by no means easy to assign every case to one of the three assortments. The principal difficulties of the tripartite

arrangement and of the other features of the International Classification have been the following:

(a) *Depressions.* The list imposes the necessity of separating depressions of a psychotic character (rubric 301) from those of a neurotic character (rubric 314); and the doctor is warned under both headings that the one excludes the other. Under the heading Neurotic Depressive Reaction (314) are listed as equivalent terms "psychogenic depression" and "reactive depression". These terms imply that the depression has an ascertainable cause to which the patient "reacts" by becoming depressed. But in many cases of depression, especially among women, which are not severe enough to be treated as psychotic, there is no such ascertainable cause. The depression is "endogenous" but not psychotic. Many psychiatrists feel that a third category of depressions is needed to accommodate intermediate cases.

It will be seen from table 33 that these two forms of depression top the list of *in*patients. Taken together, they comprise a third (33.1 per cent) of all patients; manic-depressives contributed 17.5 and neurotic depressives 15.6 per cent. Of total patients (in- and outpatients combined: table 36) they contribute more than a quarter (26.7 per cent). These two categories are therefore numerically important.

(b) *Anxiety States.* Conditions involving fears are spread over five possible rubrics. Number 310 comprises *anxiety reaction without mention of somatic symptoms.* But it is a matter of universal experience that anxiety states are more often than not accompanied by such somatic symptoms as pressure headaches, giddiness, minor alimentary and circulatory disorders, etc. It is rare that a sufferer from anxiety does not produce, in response to questioning, a physical complaint of some kind. Anxiety accompanied by somatic symptoms (called in the international list "somatization reactions" but in Great Britain better known as "psychosomatic reactions") are itemised in the international list under "*psychoneurosis affecting the circulatory system*" (rubric 315), "*psychoneurosis affecting the digestive system*" (rubric 316), and "*psychoneurosis affecting other systems*" (rubric 317). In addition to these four diagnostic groups in which anxieties and fears are prominent (rubrics 310, 315, 316 and 317), there is another diagnostic category of *Phobic Reaction* (rubric 312). But phobias are common among patients suffering from anxiety. It is in the Joint Hospital's tradition, and probably also in that of British psychiatry, to take more account of the presence of anxiety than of the accompanying psychosomatic symptoms. It will be seen (table 36) that, among our total patients, the group diagnosed as anxiety (14.1 per cent) was the second largest. There can be little doubt that this group would have been much smaller, and the group comprising other psychoneuroses (which includes the three psychosomatic categories) much larger if patients with anxiety who mentioned somatic

symptoms had, as the rubric requires, been rigidly excluded from the group of anxiety states (rubric 310).

(c) *Hysterical reactions.* In the absence of further definition, the line of demarcation separating *hysterical reactions* (rubric 311) from "*somatization reactions*" (rubrics 315-317) is also difficult to establish, and psychiatrists might differ on where to draw it. Rubric 311, the title of which is "*Hysterical Reaction without mention of Anxiety Reaction*" proceeds to specify an assortment of conversion symptoms involving bodily functions which might be regarded as "somatization reactions". Thus a hysterical fit or hysterical vomiting could be called a somatization reaction. Unless further defined, the term "somatization reaction" is sufficiently comprehensive to include symptoms associated with anxiety, hysterical symptoms and (if such are recognised as constituting a separate clinical entity) hypochondriacal symptoms.

(d) *Pathological and Immature Personalities.* In the International Classification these two conditions appear in the third main division of section five, namely that comprising Disorders of Character, Behaviour and Intelligence (rubrics 320-326). The Pathological Personality is numbered 320 and the Immature Personality 321. Yet the distinction between these two groups is not clearly defined, and the difficulties are increased by the inclusion of aggressiveness (rubric 321.2) under the heading of immature and not pathological personality. In partitioning assignments between these two categories, there is much room for differences in diagnostic habit between psychiatrists.

(e) *Hydra-headed Character of Neurotic Disorders: Accessory Chronic Disorders.* The hydra of legend had numerous heads; when one was cut off another grew in its place. Neurotic disorders likewise have many heads or aspects; and it is this "pluralistic" feature which makes agreement on the systematic classification of mental illnesses difficult. It is common to find a tense and anxious patient to be at the same time depressed, to have unwelcome preoccupations of an obsessional character, to be worried about her health or sanity, to have psycho-somatic disorders which might, when pronounced, be called hysterical, and to complain of lack of self-confidence, of a sense of inadequacy and of inferiority. The psychiatrist commonly finds himself in the dilemma of having to choose from such a miscellany what appears to him to be the most conspicuous, significant or characteristic feature as a diagnostic label. The idea of a profile rather than of a single designation will then commend itself.

This difficulty, which is deceptively concealed in most statistical presentations, is clearly exemplified by the entries made by the hospital's medical staff under the supplementary heading of *Principal Accessory Chronic Condition* which is discussed on pages 58-61 below. The matter requires a short explanation.

The Ministry of Health had requested that, during the period covered by the triennium, hospitals should use a somewhat

complex quadripartite system of diagnosis. Of every hospital case diagnoses are, when deemed appropriate, asked for under four headings. But of these, two only need be mentioned here. The first is the *Principal Disease* which should be entered in every case. The other is the *Principal Accessory Chronic Condition* as to which an entry should only be made when appropriate. The instructions read as follows: "Enter here (e.g. under the heading Principal Accessory Chronic Condition) the most important morbid condition of a chronic nature (if any) from which the patient is suffering". Thus if a patient with acute schizophrenia who has also suffered from long-standing diabetes mellitus were admitted, schizophrenia would be entered as the Principal Disease and diabetes as the Principal Accessory Chronic Condition. For this report, two comprehensive lists have been prepared in respect of the total number of patients covered in the triennium; one shows the Principal Diseases, the other the Principal Accessory Chronic Conditions. As is to be expected from a hospital which is mainly concerned with psychiatric patients, the list of Principal Diseases, which covers all patients, consists mainly of psychiatric diagnoses which fall within the rubrics 300-326 above mentioned. Indeed, ninety per cent of the recorded "Principal Diseases" are here comprised. A diagnosis of a "principal accessory chronic condition" was made of a fifth only of the total—that is to say of 1,841 out of 8,725 patients (21 per cent). But (again in accordance with expectation) these accessory conditions cover a wide range. Though the patients were relatively few, the accessory chronic conditions from which they were recorded as suffering were more numerous and covered a wider range than did the "principal diseases" of which diagnoses were made for all. Of "accessory chronic conditions", there were 203 different diagnoses; of "principal diseases", 131.

The point which it is desired to make here is the following: of 1,841 patients, 203 different accessory chronic diseases were diagnosed; but of as many as 1,350 (73 per cent) of these 1,841 patients, the recorded "accessory conditions" were psychiatric and were included in the rubrics 300-326 which appear in the Appendix. The figures are shown in table 39, page 58. The matter is here raised because it illustrates the need experienced by the consultants of the Joint Hospital for latitude in psychiatric diagnosis. A single diagnostic label is felt to be insufficient; the need for pluralism is frequently met by making a supplementary psychiatric diagnosis in the manner which the invitation to designate an "accessory chronic condition" makes possible. This need emerges in connection with the diagnoses of pathological and immature personalities mentioned above. Much here depends on the system of psychopathology in terms of which a particular psychiatrist does his thinking. If a mental disorder is regarded as the product of a fixation or early arrest of emotional development at an infantile or immature level, most of such disorders could be regarded as the result of

immaturity. The frequency with which psychiatric conditions appear in the list of principal accessory chronic conditions reflects the need for diagnostic pluralism and illustrates the peculiar difficulties of diagnosis in psychiatry.

7. A Nineteen-point Diagnostic List.

It will be seen from the Appendix that when subdivision into decimals is taken into account, section 5 of the International Classification of Diseases and Causes of Death comprises seventy-six diagnostic headings. It is thus too detailed for a breakdown by diagnosis. A condensation of the list was imperative. The simplest possible abbreviation is the above mentioned four-point classification shown in tables 35 and 37. But a more detailed classification was called for. The matter was closely discussed before the beginning of the triennium. A twelve-point list, as shown in table 33 below, was first proposed. But as frequently happens, the list was expanded to take account of some special activities in which individual members of the medical staff were interested. There emerged the nineteen-point list shown on page 50. It will be seen that, in respect of inpatients (table 32), ten of the nineteen items each comprise less than a hundred patients; and, in respect of outpatients (table 34) five. A condensed twelve-point table for inpatients is shown on page 51, wherein the twelve diagnostic groups (all except two of which exceed a hundred) are arranged (totals column) in descending order of the number of patients they contain.

Like all other classifications, the nineteen-point list is far from perfect; and some of the numbers in the totals column are too small to be meaningful. Some of its defects—for example the separation of psychotic from neurotic depression, and of anxiety states (rubric 310) from psychosomatic reactions (rubrics 315-318) and from phobias (rubric 312)—have been discussed above. But nevertheless some features of interest emerge which are discussed in chapter 4. Other abbreviations of the international list may be used in future reports. Especially welcome would be the formulation and general acceptance of a simple, unequivocal, and yet basic classification of mental disorders to which the international classification in its present or future forms (the list is subject to revision) could be adjusted. Any psychiatrist who could devise such a classification, or any psychologist—for there is some promise in this field—would perform a valuable service.

8. Use of Tables denoting individual Patients and denoting Discharges, sometimes multiple, for the same Individual.

It is not always easy to decide whether it is preferable, in medical reports, to base the tables on individual patients (who may have been admitted to wards more than once during the period under review) or on admissions (or discharges) which are sometimes multiple for the same individual. The decision will depend upon the purpose for which the figures are to be used. In, for example,

a comparison of social, demographic or economic features, it would be misleading to count any patient more than once; but in a description of the hospital's activities the number of admissions or discharges must form the basis of the tables.

The length of the period under review also has a bearing: the shorter the period, the smaller the chances of the same patient being admitted more than once; the longer the period, the greater the chances.

If a long period is covered, re-admissions may be numerous and figures become seriously misleading because of the duplication or even the multiplication of data relating to the same individual. Thus is produced an unreal inflation of the figures and an over-representation of the particulars relating to individuals admitted more than once. But difficulties arise when the datum for tabulation varies with each admission. How, for example, should the age of a patient admitted to hospital at the beginning and then, again, at the end of a decennial period be recorded in a report covering such a period? If, moreover, admissions to a hospital's outpatient department and, therefrom, to its wards are separately counted and the two sets of data separately tabulated, quite massive duplications over short periods are unavoidable.

Over a three-year span, such as is covered by this report, the disparity between the numbers of individuals and of admissions (or discharges) is not unduly large. In Table 1 the figures for the two categories (relating to individuals and discharges) are separately shown for adults and children; multiple discharges of adults during the triennium are, moreover, shown in Table 19, and of children in Table 61. It can be seen that the disparities (between individuals and discharges) are rather more pronounced for adults than for children. Discharges are counted in preference to admissions because the data for tabulation are not complete until the patient has been discharged.

In this report both methods of tabulation are used. Chapter Four is concerned with breakdowns by diagnosis. Since a different diagnosis is not infrequently made of the same patient before different discharges, the tables are here based on discharges and not on individuals. The need to take account of discharges rather than of individuals is especially obvious in Chapter Three which, as a glance at the Table of Contents will show, deals with the events relating to each admission; among these are the referring agent, the duration of stay, the investigations and treatments, the outcome of treatment and the disposal. All these are likely to differ for each admission of the same patient.

Chapter Two, however, deals with the demographic, social, and economic features of the hospital population. For obvious reasons individuals and not discharges must here be the subjects of the tables. But another glance at the eleven headings of Chapter Two, as set out in the Table of Contents, will show that the items there

dealt with vary in constancy in a manner which can cause difficulties. Of the eleven items, the only one necessarily constant and unvarying, however numerous the admissions, is the age at first marriage (if such has taken place). The only item which is necessarily inconstant, being bound to change with each admission, is the patient's age; but as the period covered by the report is short, changes in age are small. Of the remaining items, some are relatively variable, others relatively constant. The following features are relatively variable: marital status (especially in young patients), number of children (especially among young married patients), weekly income, occupation, unemployment before admission and duration of that unemployment. The following features are relatively stable: religion, number of brothers and sisters, and social class.

An attempt, however, has been made in Chapter Two to surmount the difficulties presented by the inconstancy of the data for separate admissions. There can be no doubt that a fairer picture of the demographic, social and economic background of the hospital population is provided by tabulating data (even if these are sometimes arbitrarily selected) relating to individuals rather than to discharges, and this is the course which has been followed.

As Chapter Five is a comprehensive chapter dealing with the Children's Department of the Joint Hospital, here both methods have been used, social data being tabulated by individuals, medical data by discharges (or admissions).

9. Design of Report.

The subject matter falls into natural divisions which are indicated by the titles of the chapters. It will be seen that adults and children are separately treated and that a chapter is concerned with the general practitioners who have referred patients to the adult outpatient department during the three separate years of the triennium.

Chapter Two describes the demographic, social and economic features of the hospital's adult patient population, while Chapters Three and Four deal with medical features. Chapter Five is concerned with children.

10. Registrar General's Publications and Other Sources.

In chapter two and elsewhere in this report, the hospital population is compared with that of Greater London and, in some respects, with that of the administrative County of London; it is also compared with national figures and, in chapter four, with the figures for patients in mental hospitals. Use has throughout been made of the publications of the Registrar General on the 1951 census, the reports of the Royal Commission on Population, the Family Census (1946), the annual reviews of the Registrar General and other publications. References are given in the appropriate sections.

CHAPTER TWO

DEMOGRAPHIC, SOCIAL AND ECONOMIC FEATURES OF THE JOINT HOSPITAL'S PATIENT POPULATION.

The design and content of the chapters of this report are outlined at the end of the preceding chapter. As implied in its title, this chapter is concerned with the non-medical features of the hospital population.

1. Basic Figures.

At the beginning of Chapter One are set out (table 1) the basic figures which recur in the ensuing tables. In the present chapter the figures relate solely to the number of individuals discharged from the Joint Hospital during the triennium. Patients with two or more such discharges are counted once only in the tables that follow.

It will be seen (table 1) that the total number of patients was 7,787, (3,857 males and 3,930 females). Of these 2,636 had a history of inpatient treatment (1,171 males and 1,465 females) preceded and/or followed by outpatient treatment; and 5,151 (2,686 males and 2,465 females) were outpatients without admission to the wards. Both groups contain a minority of patients admitted and discharged more than once during the triennium.

It will be seen that the total of 7,787 patients comprised more females than males; the overall ratio of males to females was 0.98 which was higher (in the sense of giving relatively more males) than the corresponding figure of 0.84 for the population aged sixteen and over in Greater London at the 1951 census. There were fewer male than female inpatients (ratio 0.80) and more male than female outpatients (ratio 1.09).

Since the hospital's beds are kept as full as possible, and since female inpatients spend rather longer in the wards than male (see table 23 below), the difference between the number of male and female *inpatients* reflects little more than the available bed accommodation. Owing to ward repairs and closures for other causes, more beds for women than men were available during the triennium. The difference between the numbers of male and female *outpatients* is mainly due to outside causes—the practice of referring agencies. Some of these agencies refer more men than women (see table 22).

In the ensuing tables in this chapter, comparisons are made with the population of Greater London as shown by the 1951 census figures. It is impossible to make exact comparisons with the population at risk of hospital treatment since the catchment area of the hospital is never precisely or rigidly demarcated. Chapter six gives an indication of the wide area from which patients were

drawn, although most came from South East London. Since, however, some indication should be given of the type of patient treated in the Joint Hospital, comparisons are made with the population of Greater London. The smaller County of London would be less satisfactory for this purpose because of the outward movement of the higher social groups to the newer suburbs beyond the County boundary in the past generation. There are within the conurbation of Greater London "enclaves" of populations with differing social characteristics, but these scarcely affect the validity of the comparison.

The source of the Greater London figures is the One Per Cent Sample Tables for Greater London, Parts I and II of the 1951 census.

2. Age of Patients.

The patients were younger than the population of Greater London in the sense that among patients there was a higher proportion of the younger age-groups. Outpatients were also younger than inpatients, and males younger than females. The average age of male patients was 37 years; of female, 40 years.

	Greater London	Hospital Population (7,787)		
		In and Out-patients combined (7,787)	In-Patients (2,636)	Out-Patients (5,151)
Males	56.9	73.7	66.0	77.0
Females	53.1	67.4	63.0	70.0

Table 2. *Age of Hospital Population* (7,787 patients).

Percentages aged over sixteen and under forty-five compared with population of Greater London.

In table 2 the figures express the percentage of persons aged *under* forty-five. Hence the higher the percentage, the younger the population. In- and outpatients are separately shown. Of males in Greater London aged 16 and over, 56.9 per cent are under 45 compared with 73.7 per cent of patients. The corresponding figures for females are 53.1 per cent (Greater London) and 67.4 per cent (hospital population).

It will also be seen that, within the hospital population, outpatients are younger than inpatients. Of male outpatients over three-quarters—77.0 per cent—are under forty-five compared with 66.0 per cent of inpatients. The corresponding figures for female patients are 70.0 and 63.0 per cent. In the hospital population young people in their late twenties and early thirties are relatively numerous both among out- and inpatients.

Age Group	Males (3,857)						Females (3,930)					
	I.P.s		O.P.s		Combined		I.P.s		O.P.s		Combined	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
16—24 ...	199	17.0	532	19.8	731	19.0 (13.6)	222	15.2	402	16.3	624	15.9 (14.2)
25—34 ...	342	29.2	908	33.8	1,250	32.4 (20.7)	363	24.8	711	28.9	1,074	27.4 (19.0)
35—44 ...	232	19.8	630	23.4	862	22.3 (22.6)	337	23.0	611	24.8	948	24.1 (19.9)
45—54 ...	192	16.4	365	13.6	557	14.4 (18.4)	288	19.7	369	15.0	657	16.7 (17.6)
55—64 ...	140	12.0	187	7.0	327	8.5 (13.1)	150	10.2	228	9.2	378	9.6 (13.8)
65— ...	66	5.6	64	2.4	130	3.4 (11.6)	105	7.1	143	5.8	248	6.3 (15.5)
Not known ...	—	—	—	—	—	—	—	—	1	—	1	—
Total ...	1,171	100.0	2,686	100.0	3,857	100.0	1,465	100.0	2,465	100.0	3,930	100.0

Table 3. *Age of Hospital Population* (7,787 patients).

Percentages in six age-groups compared with population of Greater London. Greater London proportions shown in brackets.

Table 3 shows the distribution by age-groups. It will be seen that the age group 25-34 is the best represented of the six, and better among males than females. Nearly a third (32.4 per cent) of male patients and over a quarter (27.4 per cent) of female patients are contained in this age-group. Forty-seven per cent of all patients were under 35.

That among inpatients young people are more numerous than in the population of Greater London could be in part explained by their being a selected group—selected by the hospital's medical staff. The factors which influence the selection of inpatients have been discussed above (pages 3-4). But no such selection is applied to outpatients, most of whom are referred by doctors practising in the South of London within a fairly short distance from the hospital.

Though the ratio (incidence in each age-group) of mental disorders of sufficient gravity to be classed as psychoses increases with age after the age of 50, the age-distribution of the patients suggests that the disorders, mostly minor, which lead practitioners to refer patients to the hospital, occur most frequently in the age-period when the stresses of marriage and child-bearing are felt most heavily by both sexes. Thus the activities of the hospital are mainly directed to people of a productive and socially important age-group.

3. MARITAL STATUS.

Here will be compared the proportion of single (never married) persons against married and the number of broken marriages; also the number of patients married more than once.

Age Group	Males (3,843)			Females (3,929)		
	Greater London	B/M Patients	Difference	Greater London	B/M Patients	Difference
16–24	85.7	88.6	+ 2.9	71.2	78.8	+ 7.6
25–34	28.0	45.7	+17.7	21.4	29.6	+ 8.2
35–44	12.3	22.5	+10.2	15.6	24.9	+ 9.3
45–54	8.9	17.5	+ 8.6	16.7	25.3	+ 8.6
55–64	8.2	9.2	+ 1.0	16.5	22.5	+ 6.0
65–	8.1	10.9	+ 2.8	17.0	17.3	+ 0.3
All ages	25.1	40.3	+15.2	28.0	34.1	+ 6.1

Table 4. Marital Status.

Percentages of single (never married) persons among hospital population compared with population of Greater London in six age-groups (7,772 patients).

Under columns headed Difference + = excess of single in hospital population.

Table 4 compares the percentages of single patients in six age-groups with the corresponding percentages for the population of Greater London. It will be seen that the proportion of single for

all ages is conspicuously higher for males (40.3 per cent) than for females (34.1 per cent). It will be further seen that the proportion of single persons is throughout higher than the corresponding proportion in Greater London. The difference is most pronounced among men from 25-55, being largest in the decade 25-34. Among women the difference is more uniformly distributed throughout the age-grouping.

The excess of single persons among both in- and outpatients can be explained in two different ways. First the fact of not being married might sometimes produce mental stresses of a kind which would cause patients to be referred to hospital; second the fact that a person has neurotic or psychopathic tendencies which would make him liable to be referred to hospital might militate against marriage. This last effect is produced either if the subject is deterred from marriage by neurotic fears or misgivings, or if these and other abnormal mental features make him unattractive as a marriage-partner. Marriage can either be shunned by a patient or by the person whom the patient would like to marry.

Our figures do not enable us to decide which of these two factors contribute most to the excess of single persons among patients. The majority of psychiatrists probably attach less importance to the first factor (that failure to marry is a cause of mental disturbances) than to the second (that mental disturbances cause people to shun marriage and deter others from marrying them).

Other factors, domestic and economic, which are applicable to physical illnesses, may also favour the admission as inpatients (though not as outpatients) of psychiatric patients who are single. The single patient has no marital partner to care for him at home. Also, if they are still at work, single persons usually have fewer commitments than married and may therefore find it easier to enter hospital.

Outcome of Marriage	Males (2,294)		Females (2,590)		Totals (4,884)	
	Nos.	%	Nos.	%	Nos.	%
Marriage broken by death, divorce or separation	369	16.1	549	21.2	918	18.8
Marriage broken by:—						
(i) death	83	3.6	284	11.0	367	7.5
(ii) divorce	62	2.7	69	2.7	131	2.7
(iii) separation... ...	224	9.8	196	7.5	420	8.6

Table 5. *Marital Status.*
Broken marriages among 4,884 married patients.

Table 5 shows the incidence of broken marriages. Marriages can be broken in two ways which concern us; first by the death of a partner, second by divorce or separation (judicial and non-judicial including desertion).

Age of Groups	Males			Females		
	No. married	No. widowed		No. married	No. widowed	
		Hospital Population	Expected No.		Hospital Population	Expected No.
	(a)	(b)	(c)	(d)	(e)	(f)
16–24	83	2	0.13	132	—	0.28
25–34	677	7	2.47	756	18	10.90
35–44	665	10	7.03	712	24	30.26
45–54	458	17	13.77	491	59	59.64
55–64	296	22	23.04	293	85	89.57
65–	115	25	30.13	205	98	122.62
Total	2,294	83	76.57	2,589	284	313.27

Table 6. *Marital Status.*

Numbers of Widowed among 4,883 married patients in six age-groups compared with expected numbers on the basis of Marital Status in the population of County of London at the 1951 census.

Table 6 compares by age-groups the numbers of widowed patients in the hospital population with the expected numbers calculated from the corresponding widowhood ratios of the population of the County of London at the 1951 census. (Figures for Greater London are not yet available from the 1951 census).

In none of the six age-groups is the difference statistically significant, but the numbers for the hospital population are small. The number of widowed patients exceeds the expected number in the age-group 25-34. But the numbers of patients widowed (seven men and eighteen women) are too small to provide a basis for conclusions, though they are perhaps suggestive.

Age Groups	Males			Females		
	No. Married	Hospital Population	Expected No.	No. Married	Hospital Population	Expected No.
	(a)	(b)	(c)	(d)	(e)	(f)
16–24	83	—	0.18	132	—	0.48
25–34	677	24	7.46	756	17	16.19
35–44	665	26	12.82	712	29	22.37
45–54	458	10	7.90	491	15	13.09
55–64	296	2	3.01	293	8	4.15
65–	115	—	0.61	205	—	0.94
Total	2,294	62	31.98	2,589	69	57.22

Table 7. *Marital Status.*

Numbers of Divorced among 4,883 married patients in six age-groups compared with expected numbers.

Table 7 compares the numbers of divorced persons with the expected numbers as does table 6 for the widowed. For male patients the proportion divorced in the age-group 25-34 years is three times, and in the age-group 35-44 years is twice, the expected number; these differences are statistically significant. In the other age-groups for males the differences are small and statistically insignificant. For females the striking feature of this table is the relative correspondence between the observed and expected numbers in contrast to the differences observed for the males.

It is possible that this contrast may be related to the disturbances of the war years. Most of the men aged from 25-44 who were hospital patients during the triennium 1949-51 had been eligible for war service between 1939 and 1945 and had been away from home. The circumstances of divorce during the post-war years may have imposed greater stresses on men than women. It will be interesting to see if these differences are repeated in later triennia when the after-effects of war will have receded.

There is no comparable source of control figures for the patient population living in a condition of separation from their spouses (both judicial and non-judical). It will be noted (table 5) that among male married patients there were more than three times as many separations (9.8 per cent) as divorces (2.7 per cent), and that among female patients there were more than twice as many (7.5 per cent of separations against 2.7 per cent of divorces). These substantial figures for separations are almost certainly larger than those obtaining in the control population of the County of London. Free legal aid, through the Legal Aid and Advice Act, 1949, was made available in October, 1950. The number of filed divorce petitions then jumped from 29,096 in that year to 37,637 in 1951, and divorce cases have since represented about four-fifths of all legal aid cases. It would not therefore be surprising if, in future triennia, the figures for divorce among the hospital population gained at the expense of those for separation.

The fact that, among married male patients one in ten, and among married female patients one in thirteen, were judicially or non-judicially separated from their spouses is in full accord with clinical experience as to the important contribution made by marital stresses to psychiatric illness. But how far the marital stress is the primary cause of the illness, or alternatively how far an antecedent mental abnormality is the cause of the marital stress and of the ensuing broken marriage, is not easy to determine.

The front page of the case notes contains a question as to whether the patient has been married more than once. The question was answered in respect of 4,834 out of the total of 4,884 married patients—over 99 per cent of cases. Of these, 348 (7.1 per cent) had been married more than once.

	No. of known married patients	No. married more than once	
		No.	%
Males	2,294	154	6.7
Females	2,590	194	7.5

Table 8. *Marital Status.*
Proportion married more than once among 4,884 married patients.

The proportions are closely similar for the two sexes. Comparisons with norms, if such are available, should take account of the comparatively low average age of our patients (males 37, females 40). (See page 14 above). The proportion of women married more than once in Great Britain is 3.4 per cent; but this refers to women of all ages whereas the hospital population comprises women of a somewhat younger age-group. The indications are, therefore, that proportionally more women in the hospital than in the general population have been married more than once.

4. RELIGION.

The distribution among in- and outpatients combined is as follows:

Religious Affiliations	Males		Females		Totals	
	Nos.	%	Nos.	%	Nos.	%
Church of England ...	2,725	72.6	2,922	75.5	5,647	74.1
Roman Catholic ...	464	12.3	401	10.4	865	11.3
Non-Conformist ...	214	5.7	274	7.1	488	6.4
Jewish	173	4.6	162	4.2	335	4.4
Other	182	4.8	109	2.8	291	3.8
Totals	3,758	100.0	3,868	100.0	7,626	100.0
Not known	99		62		161	

Table 9. *Religious Affiliations.*
7,626 patients.

It will be seen from table 9 that it was not known of 161 of the total of 7,787 patients (2 per cent) to what religions they subscribed. There remain 7,626 patients about whom information is available.

There are no figures for Greater London relating to religion with which the hospital figures may be compared. Religious affiliation varies much by locality even within a small area. Roman Catholics, represented by 11 per cent of patients, are given by the Catholic Year Book as forming 7 per cent of the population of England and Wales.

The distribution by religion as shown in table 9 differs somewhat from that shown for children in Chapter Five (table 64). Some remarks on the differences are offered in that chapter.

5. Age at First Marriage.

Of the total of 4,884 married patients, the age at first marriage was not known of 151, (3.1 per cent). The information was thus available for 4,733 patients—2,222 males and 2,511 females.

The proportions who were first married at different ages are shown in table 10:

Age at First Marriage	Males (2,222)		Females (2,511)	
	No.	%	No.	%
Under 20	69	3.1	380	15.1
20–24	875	39.4	1,196	47.7
25–29	796	35.8	642	25.6
30–34	298	13.4	186	7.4
35–39	124	5.6	64	2.5
40–45	43	1.9	25	1.0
45+	17	0.8	18	0.7

Table 10. *Age at first Marriage.*
4,733 patients: Seven Age Groups.

The fact should be recalled (table 4) that the proportion of single (never married) persons is conspicuously higher among our patients than among the general population of Greater London, the excess of single being specially conspicuous among males.

Over the past thirty years there has been a trend towards earlier marriage, particularly among young women under twenty and young men under twenty-five. The ages of males and females at first marriage in England and Wales have been averaged over the period 1919-49, and these are shown with corresponding averages for the hospital's in- and outpatients in table 11.

	Average age at marriage				Difference between ages of males and females
	Males		Females		
	No.	Age at marriage	No.	Age at marriage	
Patients 1949–51 ...	2,222	27.0	2,511	24.8	2.2
E. & W. 1919–48 ...	27.5		25.2		2.3

Table 11. *Average Age at First Marriage.*
4,733 patients compared with national average for England and Wales over the years 1919-1948.

It will be seen from table 11 that of both male and female patients the average age at marriage was little different from that of the general population.

6. Number of Brothers and Sisters (Size of Patients' Sibships).

Age Group	Males		Females	
	Nos.	Average family size	Nos.	Average family size
16–24	701	3.7	607	3.7
25–34	1,202	4.0	1,037	4.4
35–44	833	5.0	918	4.9
45–54	520	5.2	633	5.4
55–64	304	5.7	355	6.1
65–	123	5.5	226	6.4
Totals	3,683		3,776	

Table 12. *Size of Patients' Sibships* (*including the Patient*).
7,459 patients in six age-groups.

Table 12 shows the average family size (including the patient as one child in the family) of the families from which the Joint Hospital's patients were drawn. (The figures are of the number of children born to the patients' mothers and not of surviving brothers and sisters). The increase in family size with advance in age is a reflection of the trend to smaller families between 1880 and 1930.

However, the recorded (observed) sibships of all hospital patients overstate the size of families for the reason that large families have more members at risk of becoming a hospital patient. If 10 per cent of the population are admitted to hospital then every family of 10 persons is statistically likely to be represented; but, since it takes two families of five persons each to produce one patient, only half of such families may expect to be represented. There is thus a bias in favour of the larger families. Greenwood and Yule (*Journal of the Royal Statistical Society, 1914*) have shown that if the risk of admission to hospital is low this bias can be removed by dividing the observed frequencies by the respective sizes of family (sibships) before the calculation of averages.

In table 12a are shown the adjusted family size figures in accordance with the correction suggested by Greenwood and Yule. In Column (d) is given the probable mean date of the parents' marriage—a crude estimate having regard to the wide span of years over which the parents may have been married. In column (e) is shown the corresponding number of live births for marriage of the genera-

tion quoted in column (d).* This table suggests that the family size of the Joint Hospital's patients is not dissimilar from the national experience. The apparent disparity of the age-groups over 45 is probably due to an understatement by the patient of his mother's live births. The generation of these patients suffered from a high infant mortality and it is probable that brothers and sisters who died in infancy were forgotten (or not even known) by the patients.

	Corrected average family size		Probable mean date of parents' marriage	General Population: No. of live births per woman of generation shown in column (d)
	Males	Females		
(a)	(b)	(c)	(d)	(e)
16–24	2.4	2.4	1920	2.5
25–34	2.8	2.9	1910	3.0
35–44	3.2	3.3	1900	3.4
45–54	3.6	3.7	1890	4.3
55–64	4.1	4.6	1880	5.8
65+	4.8	4.9	1870	

Table 12a. *Adjusted Size of Patients' Sibships compared with General Population (Gt. Britain).*

7,459 patients in six age-groups.

7. Fertility.

Fertility depends upon two factors, the age of patients and the duration of their marriages. In the course of the triennium, the duration of marriage was only recorded for the hospital population during 1951. Table 13, which takes account of married patients only, is therefore based on a calculation of the duration of marriage based on the average age at marriage. This for males was 27, for females 25. The midpoint of each decennial age-group is taken as expressing the average age of the group—e.g., 30 for the age-group 25-34, 40 for the age-group 35-44, etc.; the average duration of marriage is obtained by subtracting from these average ages of decennial age-groups the figures 27 and 25 which respectively express the average age at marriage of males and females.

The method is unsatisfactory for several reasons and provides no basis for calculating the duration of marriage for the youngest age-group aged 16-24. For future triennial reports the duration of marriage will be known.

Of the total of 4,884 patients who had been married information as to number of children was not available in respect of fifty-two (one per cent). Table 13 is therefore based on 4,831 patients (one

* From Glass and Grebenik, 1954. *Trend and Pattern of Fertility in Great Britain* (Report on the Family Census of 1946).

age not known). The figures giving "general experience" are taken from the Royal Commission on Population (Family census).

Age Group	Average duration of marriage (years)	Average No. of Children Born Alive			No. of Patients
		General experience: Gt. Britain	Patients 1949–51	Difference	
Males					
16–24			0.6		80
25–34	3	1.0	1.2	+ 0.2	674
35–44	13	1.9	1.7	— 0.2	659
45–54	23	2.3	2.0	— 0.3	450
55–64	33	3.0	2.3	— 0.7	290
65–	43	4.0	2.6	— 1.4	114
					2,267
Females					
16–24			0.7		132
25–34	5	1.0	1.4	+ 0.4	751
35–44	15	1.9	1.6	— 0.3	706
45–54	25	2.3	2.2	— 0.1	488
55–64	35	3.0	2.4	— 0.6	290
65–	45	4.0	2.7	— 1.3	197
					2,564

Table 13. *Fertility.*

Number of Children born alive by Duration of Marriage: 4,831 married patients compared with General Female Population: Great Britain (Royal Commission on Population).

It will be seen from table 13 that the fertility of the Hospital population is below average for all age-groups except that of 25-34.

The comparison offered here is based on the experience of the country as a whole. Fertility rates vary by regions and type of community—urban compared with rural—and differences noted here may be accountable in these terms. (In 1949 the adjusted birth rates for London and the South East counties were only 89 per cent of that for England and Wales). Moreover, although male married patients are shown in this table, it is not their fertility but that of their spouses that is really in measurement. However, as the average differences between husbands' and wives' ages at marriage in the patient population are not dissimilar from the general experience, it is fair to relate the fertility experience of these husbands to the corresponding fertility rates for females of an appropriately younger age.

The relatively high fertility of the younger age-groups may have clinical significance. It is possible that the experience of early pregnancy, and still more so that of having unplanned pregnancies, may inflict on young and immature people stresses which cause

doctors to refer them to a psychiatric hospital. Though information is not recorded for purposes of tabulation as to whether the pregnancies of patients were planned, the question is nearly always asked and negative replies are frequent. Indeed the matter was thought to have such clinical importance that, in the course of the triennium, the hospital arranged for a special weekly session on birth control to be held in the hospital. This session is now (1954) taken by a woman doctor who is a member of the junior staff. The medical staff agree that it serves a useful purpose.

The desire to have a large family is felt and sometimes acted upon by an appreciable though at present unassessable fraction of the general population. Most psychiatrists would probably concur that this desire was less often found among sufferers from neurosis than in the general population. Indeed, the anxieties of many neurotics commonly cause them, if women, to have misgivings about pregnancy, parturition, and their capacity to deal with more than one of two children; and, if men, to shrink from adding to the worries and responsibilities of their lives. Hence it is possible that some young patients who have children early may thereafter be reluctant to add to their families, so that in later years their fertility will fall behind the average of their age-group.

No. of Children	Males		Females		Totals	
	No.	%	No.	%	No.	%
(a)	(b)	(c)	(d)	(e)	(f)	(g)
None ...	562	24.8	612	23.9 (21.6)	1,174	24.3
One ...	640	28.3	769	30.0 (30.3)	1,409	29.2
Two ...	558	24.6	643	25.0 (26.5)	1,201	24.8
Three ...	243	10.7	272	10.6 (11.8)	515	10.7
Four ...	124	5.5	112	4.4 (5.0)	236	4.9
Five to six...	90	4.0	103	4.0 (3.3)	193	4.0
Seven to nine	38	1.6	41	1.6 (1.3)	79	1.6
Ten and over	12	0.5	13	0.5 (0.2)	25	0.5
Totals ...	2,267	100.0	2,565	100.0	4,832	100.0
Not known	27		25		52	
Total ...	2,294		2,590		4,884	
Average No. of children	1.71		1.68		1.69	

Table 14. *Fertility.*

Distribution of Family size (number of children) among 4,382 married patients. For meaning of figures in brackets see text.

Table 14 shows the distribution of family size (number of children) among married patients of all ages. Of these, 2,565 were women (column d) and among these were 487 aged over 55 (table 13, last column). The average number of children for male and

female patients combined was 1.69, the figures for the two sexes being closely similar. The average family size of all married women aged *under fifty* for England and Wales at the time of the 1951 census was 1.69 children, a figure indistinguishable from that (1.68) for married female patients of all ages.

The unbracketed figures in column (e) show the distribution of family size among 2,565 female patients; the bracketed figures show the corresponding proportions for England and Wales at the 1951 census. The bracketed and unbracketed figures differ little. But the comparison suffers from the fact that the national figures exclude women aged over fifty while the hospital figures take account of some 500 or more women over that age whose fertilities averaged higher than those of younger women (table 13). There can be little doubt that if the national figures included women of all ages, as do the hospital figures, they would show higher fertilities, thus substantiating the comparisons shown in table 13 which strongly suggest that the fertility of hospital patients is slightly lower than the national average.

Table 14 (column g) shows that a quarter (24.3 per cent) of married patients were childless and that over half (53.5 per cent) had not had more than one child. The small number of large families is also perhaps noteworthy: only 6.1 per cent of married patients have had more than four children and 11.0 per cent more than three.

8. Social Class.

At every census the Registrar General asks for particulars of occupation. The classification of occupation extends to something like a thousand items. The Registrar General further allocates each occupation to one of five social classes as follows:

Class I	Professional, etc., occupations
Class II	Intermediate occupations
Class III	Skilled occupations
Class IV	Partly skilled occupations
Class V	Unskilled occupations

In the record of their occupation male patients were classified according to the occupation usually followed, disregarding temporary changes or periods of unemployment caused by their illness. Similarly with females who were gainfully employed full-time; the social class grading for these patients followed from their occupational grouping. Married women employed part-time and housewives with no outside employment were allocated to the social class grading of their husbands' occupation. Retired patients were allocated to the social class comprising their normal employment before retirement. For married women this information was not always easy to obtain; hence married women figure largely in the category "not known".

Of the total of 7,787 patients, information on social class was not available for 535 (81 males and 454 females). Table 15 is therefore based on 7,252 patients.

		Social Class				
		I	II	III	IV	V
Great London Males only		4.9	16.6	54.7	10.7	13.1
Males	Inpatients (1,145)	9.5	18.5	49.2	11.0	11.8
	Outpatients (2,631)	3.3	12.0	53.4	13.5	17.8
Females	Inpatients (1,273)	6.4	15.6	63.9	10.6	3.5
	Outpatients (2,203)	2.1	11.0	66.1	14.7	6.1

Table 15. *Social class distribution.*

3,776 males (compared with distribution in Greater London) and 3,476 females: Percentages.

The following points in table 15 are noteworthy.

Males

Among inpatients there are relatively more males in classes 1 and 2 than in Greater London, while among outpatients males are under-represented in the first three classes.

Females

In both categories females have a more median distribution than males, there being relatively fewer in Class 1 and still fewer in Class 5, while there are conspicuously more in Class 3; and if female outpatients be compared with female inpatients, it will be seen that representation in Classes 1 and 2 is smaller.

The one per cent sample tables do not show figures for social class of females in Greater London.

The higher social class of inpatients compared with outpatients is explained by the factors which influence admission of patients into the Joint Hospital. These were discussed on pages 3-4. Why females should, in both groups, have a narrower distribution than males is not entirely clear. It is possible that conditions of life in the lower middle classes, wherein appearances have to be kept up on relatively small incomes and wherein there is much sensitiveness to the opinions of neighbours, may be more productive of mental stresses for females than males. But it is also possible that the referring habits of doctors outside the hospital may have an undetected bearing.

9. Weekly Income.

The value of table 16 is largely vitiated by the high proportion of cases in which the information was not available (34 per cent: 32 per cent males and 36 per cent females).

The question about gross weekly income (always a delicate question, reminiscent of the means test, which it is sometimes tactful not

to ask) is usually put by the psychiatric social worker. It is dealt with as a uniform routine in the outpatient department; but when a patient has been admitted to a ward, the matter is sometimes postponed if the patient is acutely ill or unfit for other reasons to be questioned.

	Over £12	£7–12	£4–7	Under £4	Not known	Total patients
Male I.Ps. ...	11.2	28.3	49.3	11.2	528	1,171
Male O.Ps. ...	5.8	28.2	57.8	8.2	715	2,686
Female I.Ps. ...	10.9	26.5	45.6	17.0	641	1,465
Female O.Ps. ...	6.8	29.0	44.4	19.8	784	2,465

Table 16. *Usual Weekly Income* (*gross*).
5,119 patients: 2,614 males, 2,505 females.

It is to be noted that single patients are here included with the married, widowed, divorced and separated. Of all patients the total family income (gross), including the husband's earning as well as pensions, benefits and allowances, is asked.

During the triennium the question about weekly income, as printed on the front sheet, asked about "usual" and "present" income. Male patients are commonly out of work when referred to hospital and there is often a difference between the two incomes, which has a bearing on the patient's present problems. The above table is based solely on the *usual* income.

About half the 5,119 patients fall into the income bracket £4—7.

Male outpatients, for a reason which is not obvious, are the least variable of the four categories. They show the smallest percentage in the highest (over £12) bracket (5.8 per cent) and also the smallest in the lowest (under £4) bracket (8.2 per cent). Their representation is highest in the £4—7 bracket (57.8 per cent).

There are proportionately more females (17.0 per cent of inpatients and 19.8 per cent of outpatients) in the lowest bracket of under £4 than there are males (11.2 per cent of inpatients and 8.2 per cent of outpatients). This difference is probably accounted for by the fact that unskilled female labour, especially in domestic work (10.4 per cent of female patients were engaged in "personal service") is badly paid.

More inpatients (males 11.2 per cent and females 10.9 per cent) appear in the top bracket (over £12 a week) than do outpatients (males 5.6 per cent and females 6.8 per cent). This difference accords with differences between in- and outpatients in respect of social class (table 15). What is the explanation of this difference? Some possible causes were discussed in the first chapter. It may

perhaps be that reactions to stresses arising from pressures of responsible and semi-responsible positions, which are relatively well paid, respond better to inpatient than outpatient treatment. This consideration would mainly apply to males. But the hospital population also contains a large fraction (34 per cent; table 4) of spinsters, some of whom hold responsible positions in business and the professions. It is shown in table 17 that of the total number of 3,930 females who were discharged from the hospital during the triennium, 5.6 per cent followed professional and technical occupations.

There are more male in- than outpatients in the lowest income bracket of under £4 a week (11.2 against 8.2 per cent). The difference, which is not pronounced, may be in part due to the presence at Bethlem of an inpatient unit for male adolescents most of whom are in receipt of low wages.

10. Occupation.

Occupation varies much by locality. Hence the comparison shown in Table 17 of the occupational distributions of the hospital and Greater London populations is probably less meaningful than other such comparisons made in this chapter. Indeed, it is somewhat surprising that the two distributions are so similar.

The following points in table 17 are noteworthy:

(1) Of 3,930 female patients, 40.9 per cent were housewives not employed outside the home. Of 3,857 male patients, 93.4 per cent are assignable to classifiable occupations; the large proportion of housewives reduces the corresponding figure for females to 46.4 per cent. That a patient is assignable to an occupation does not imply that he is engaged in that occupation when he first attends hospital, for about half our patients are unemployed at their first attendance. It implies that, when asked by the psychiatric social worker, he gives that occupation as his.

(2) A comparison of figures for our patients and those for Greater London show a fairly close correspondence. The most conspicuous difference is that clerical occupations (clerks, typists, etc.) figure more prominently among patients than in the general population (males 14.8 against 9.0 per cent, and females 15.8 against 11.5 per cent). It is impossible to determine how far this difference is respectively due to occupational features of the hospital's catchment area or to proneness to mental breakdown among clerical workers.

(3) Among male and female patients, clerical occupations are most numerous; they are followed among males by metal, manufacturing, engineering, etc., and by transport and communications, and among females by personal service.

(4) Professional and technical occupations (code numbers 760-819) are followed by 7.0 per cent of our male and 5.6 per cent of our female patients. Both figures, especially that for women, are in excess of those for Greater London population proportions.

Occupation Code No. Census 1951 Classification	Occupations Abbreviated and Grouped	Males		Females	
		B/M Pats. (3,857)	Greater London 1951 (1)	B/M Pats. (3,930)	Greater London 1951 (2)
010–30	Agriculture	1.6	0.9	0.2	0.1
110–279	Metal manufacturing Engineering, etc.	11.1	13.0	0.6	1.2
280–349 380–419	Textile Workers ...	1.0	1.6	2.4	3.4
470–489	Wood, cane and cork ...	1.9	3.0	—	0.1
500–539	Paper, Printing, etc. ...	1.6	2.0	0.3	0.7
580–599	Building	4.2	5.1	—	—
600–669	Painters and Decorators	2.8	2.7	—	0.1
610–629	Administrators, managers	3.0	3.8	0.3	0.5
630–709	Transport and Communications	10.4	11.0	1.4	1.1
710–759	Commercial (excluding clerical) finance and insurance	9.3	9.8	3.9	4.0
760–819	Professional and technical (excluding clerical)	7.0	6.0	5.6	3.5
861–888	Personal Service: domestics, waiters ...	5.3	4.3	10.4	9.7
890–895	Clerks, typists, etc. ...	14.8	9.0	15.8	11.5
900–909	Warehousemen, storekeepers, packers, bottlers	2.6	2.7	1.3	1.4
930–979	Other and undefined occupations	16.8	14.2	4.2	4.0
	Total occupied ...	93.4	89.1	46.4	41.3
Retired or not gainfully employed...		2.6	10.9 (3)	1.4	58.7 (3)
Unemployed (other usual occupation not specified)		3.0		1.0	
Housewives				40.9	
Married women engaged in part-time work				1.5	
Occupation not stated		1.0		8.8	
Total		100.0	100.0	100.0	100.0

(1) Total population, Greater London, Males 1951 = 3,020,900.
(2) Total population, Greater London, Females 1951 = 3,591,700.
(3) Includes housewives and students but not persons out of work.

Table 17. *Principal Occupations of* 7,787 *patients compared with Population of Greater London* (1951) *aged* 15 *Years and over. Per cent distribution.*

11 UNEMPLOYMENT.

(*A*) *Numbers of Unemployed.*

Table 18 shows how many patients were unemployed or had been compelled to give up their work before being admitted to hospital.

	Total Nos.	Employment Status N.K.*		Employment Status "known"	Unemployed		
		Nos.	%		Nos.	% of "known"	
Male I.Ps.	1,171	165	14.1	1,006	640	63.6	46.1
Male O.Ps.	2,686	215	8.0	2,471	962	38.9	
Female I.Ps.	1,465	851	58.1	614	429	69.9	54.1
Female O.Ps.	2,465	1,263	51.2	1,202	554	46.1	
Totals ...	7,787	2,494	31.8	5,293	2,585	48.8	

* Includes housewives not gainfully employed.

Table 18. *Unemployment.*

Numbers and Percentages unemployed before Admission as In- or Outpatients: 7,787 patients.

The following points in table 18 are noteworthy:

(1) Of the total 7,787 patients, the employment status was not known of 32 per cent. Housewives not gainfully employed are included in this figure. Of the 5,293 patients of whom the relevant information was available, 2,585 or 49 per cent, were unemployed when they were admitted to the wards or the outpatient department.

(2) Of the large proportion of "not known" cases (numbering 2,494 or 32 per cent of the total), females are in a large majority (the fact was recorded in table 17 (Occupation) that 41 per cent of our female patients were counted as housewives). It is here again noticeable (as in table 16 which dealt with weekly income) that the proportion of "not knowns" is higher for in- than for outpatients (14.1 per cent male I.Ps. against 8.0 per cent male O.Ps.; and 58.1 per cent female I.Ps. against 51.2 per cent female O.Ps.).

(3) There was more unemployment among in- than outpatients. Among males, 63.6 per cent of inpatients were unemployed when admitted compared with 38.9 per cent outpatients; and the corresponding figures for females were 69.9 against 46.1 per cent. This is in accordance with expectation, seeing that as a rule inpatients are more seriously ill than outpatients and are therefore more apt to be incapacitated before admission.

(4) More females than males were unemployed on admission—54.1 against 46.1 per cent. This difference may be partly due to the greater seriousness of unemployment for men than women. The man is commonly the breadwinner, and hence his family suffers with him from his unemployment. The figures for unemployment among women, which exclude housewives not gainfully employed, mainly comprise single women, many living with their families, and those

housewives who are gainfully employed outside the home. Unemployment has less serious effects when suffered by these than by men.

(*B*) *Duration of Unemployment.*

Table 18a shows the duration of unemployment among the 2,585 patients shown in table 18 as those whose employment status was known and who were unemployed when admitted to the in- or outpatient department.

	No. of unemployed	Period of unemployment: Percentages		
		Under one month	One month to a year	1 year and over
Male I.Ps. ...	640	37.5	42.5	20.0
Male O.Ps. ...	962 } 1,602	43.1 } 40.9	38.4 } 40.0	18.5 } 19.1
Female I.Ps. ...	429	35.7	43.8	20.5
Female O.Ps.	554 } 983	37.5 } 36.7	43.7 } 43.7	18.8 } 19.6
Totals ...	2,585	39.3	41.4	19.3

Table 18a. *Unemployment.*
Duration among 2,585 patients.

It will be noted that the duration of unemployment was slightly longer for women than men. In table 18a, this duration has been divided into three periods: under one month, one month to a year, and one year and over. The proportion of men and women unemployed for a year and over is closely similar, and the figures for in- and outpatients are also similar. But rather more women than men have been unemployed for the middle period of a month to a year—43.7 against 40.0 per cent.

Inpatients of both sexes have been longer unemployed than outpatients, though the differences are not striking. More in- than outpatients have been unemployed for the middle period (males only) and for a year and over.

Not shown in the above condensed table is the fact that the duration of unemployment increases with the patient's age. This is in accordance with general experience.

The findings about the incidence and duration of unemployment among patients set forth in tables 18 and 18a are in accordance with expectation. The relevant information is available for more men than women because fewer of the latter are gainfully employed outside the home; in respect of those of whom this information was to hand, half of the overall total were unemployed when they first presented themselves at hospital. Relatively more women than men were unemployed on first appearance and, as a group, they had been longer unemployed than men; more in- than outpatients had been unemployed, and as a group the duration of their unemployment had been slightly longer.

CHAPTER THREE

THE PATIENT AND THE HOSPITAL

In Chapter Two the demographic, social and economic features of the Joint Hospital's patient population were considered. In this chapter will be reviewed the patients' contacts with the hospital. These have both administrative and clinical features.

It will be convenient to take these contacts in chronological order. Events connected with admission will be followed by those relating to stay in hospital (in respect of inpatients) and to number of attendances (of outpatients); these will be followed by the conditions and circumstances of discharge.

Only one of the tables (table 27: Outcome of Treatment, page 43) is based on assessment; the rest are compiled from objectively verifiable information.

1. Previous Admissions:

Many psychiatric disturbances are cyclical, tending to recur according to a recognisable pattern. Many neurotic patients have a low resistance to stress and break down easily and repeatedly. If they are satisfied by the treatment they receive at a hospital, they come again; if not they seek out other hospitals. It is of interest to those concerned with the organisation of mental health services to know what proportion of public money, doctor time and bed accommodation is applied to a minority of patients who repeatedly seek treatment. The facilities in London are so large and co-ordination between the numerous hospitals and psychiatric units so difficult that an answer is not easily obtained. The matter could best be investigated in a provincial town with a population of about a million, the psychiatric services of which could be co-ordinated by an area psychiatrist and, if need be, centralised in a single psychiatric unit.

The number of earlier receptions or admissions of a patient depends on how a reception or admission is defined. The Joint Hospital's convention is to treat as an admission to the wards (in-patient admission) every patient so admitted irrespective of the length of time that has elapsed since his previous admission to the wards of the Joint Hospital. This is the universal hospital practice. Admissions to the outpatient department are less easy to co-ordinate with accepted standards. Our practice is to treat as an admission any patient who has not attended the hospital for a period of three months, and has not been told to return (as part of a follow-up, or supportive regime) within more than three months. Our definition of a new admission, or reception, thus turns on what we call "the three months rule".

The number of previous admissions to a psychiatric unit will thus depend much on the length of time specified in that unit's definition of an admission. Difficulties especially arise in connection with how many separate admissions to count in respect of a patient who attended the outpatient department before being admitted to a ward, and who, after discharge from the ward, again attends the outpatient department.

In the preceding chapter, account was taken only of *individuals*, irrespective of how often they were admitted or discharged during the triennium. Most of these individuals were discharged once only during the period. A minority of 938, however, were discharged more than once. These multiple discharges were distributed as follows:

	In-patients	Out-patients	Totals
Males	226	150	376
Females	383	179	562
Totals	609	329	938

Table 19. *Multiple Discharges during the Triennium among* 7,787 *patients.*

The figures shown in table 19 imply that 8.9 per cent of males and 12.5 per cent of females were discharged more than once and a few more than twice during the triennium.

For outpatients who were warded during the period, a discharge from the outpatient department, either before or after admission to the wards, or both before and after such admission, was also counted. Hence a patient treated for the same illness could be thrice discharged—from the outpatient department into a ward, from a ward to the outpatient department, and finally from the outpatient department to his general practitioner. A classification by *discharges* (occasionally multiple for the same individual) rather than by *individuals* is necessary for a breakdown by diagnosis as shown in the tables in Chapter Four. A patient may present different clinical pictures at two separate admissions; different diagnoses are then likely to be made.

A classification by discharges is also necessary when dealing with investigations, treatments, outcome of treatments, disposals and other events considered in this chapter. These are particular to a given admission. Reference to table 1 will make it clear whether, in the ensuing tables, individuals or discharges are in question.

This matter presented difficulties during the triennium under review and the practice was changed in the middle. Table 19a is restricted to admissions to the wards for the single year 1951—the

last of the three—and shows the number of previous admissions to the wards of the Joint Hospital at any earlier time in the patient's life.

	Total Patients	Previous Admissions (Percentages)				
		None	One	Two	Three	Four+
Males	545	85.1	11.7	2.2	0.6	0.4
Females ...	681	82.9	13.4	2.9	0.7	0.1
Total ...	1,226	83.9	12.6	2.6	0.7	0.2

Table 19a. *Previous Admission, at any time, of Inpatients to the Adult Wards*: 1951 *only*.
1,126 patients.

Seven of the above-mentioned patients had also been admitted as children to the Joint Hospital's child psychiatric unit.

It will be seen from table 19a that:

(1) Sixteen per cent of inpatients had been inpatients before.

(2) Slightly more females than males had been previously admitted—17.1 against 14.9 per cent.

2. Relatives treated at the Joint Hospital.

	Totals	Not known	Known	Relatives not treated Nos.	%	Relatives treated Nos.	%
Males ...	4,233	167	4,066	3,8 2	94.0	244	6.0
Females ...	4,492	165	4,327	3,997	92.4	330	7.6
Totals ...	8,725	332	8,393	7,819	93.2	574	6.8

Table 20. *Relatives previously treated at the Joint Hospital.*
8,725 In- and Outpatient Discharges.

The question, which was asked as a routine, was well answered. The number of "not knowns" is small. It will be seen from table 20 that 6.8 per cent of patients had relatives who had been treated at the Joint Hospital, the proportion being slightly larger for women than men—7.6 against 6.0 per cent.

3. Referring Agencies.

In- and outpatients will be separately considered.

It will be seen from table 21 that the referring agencies are tabulated in a descending order of the total columns. The outpatient department easily comes first. The observation ward is a bad second and general hospitals a bad third.

	Males and Females Combined		Males		Females	
	Nos.	%	Nos.	%	Nos.	%
1. Outpatient Department	1,819	56.1	804	57.6	1,015	54.9
2. Observation Ward	452	13.9	211	15.1	241	13.1
3. Psych. Unit or Dept. of General Hospital	172	5.3	68	4.9	104	5.6
4. B/M Domiciliary Service	170	5.2	45	3.2	125	6.8
5. General Practitioners	137	4.2	57	4.1	80	4.3
6. Consultant psychiatrists outside B/M hospital ...	112	3.5	54	3.9	58	3.1
7. Special research Depts. B/M Hosp.	107	3.3	38	2.7	69	3.7
8. Consultant psychiatrists on B/M staff	94	2.9	38	2.7	56	3.0
9. Non - psychiatric hospital or department	74	2.3	28	2.0	46	2.5
10. Mental Hospital ...	41	1.3	17	1.2	24	1.3
11. Probation Service Remand home, Court or prison ...	5	0.2	5	0.4	—	—
12. B/M Children's Dep.	4	0.1	2	0.1	2	0.1
13. Child Guidance Unit outside Joint Hospital	4	0.1	2	0.1	2	0.1
14. Government Dept.	3	0.1	2	0.1	1	0.1
15. Other Referrals ...	71	2.2	37	2.6	34	1.8
Total Referrals... ...	3,265		1,408		1,857	
No. of patients involved in above referrals ...	3,245		1,397		1,848	

Multiple referrals in this table. Hence percentages, when added, exceed 100.

Table 21. *Referring Agencies.*

3,245 Inpatient Discharges.

The following points are noteworthy:

(1) Fifty-six per cent of warded patients are admitted through the outpatient department.

(2) The Observation Ward (at St. Francis' Hospital) which is staffed by doctors from the Joint Hospital, furnishes much the largest fraction (13.9 per cent) of the patients recorded as being referred otherwise than through the OPD. These did not pass through the outpatient department on the way in, but many of them did so after discharge.

(3) The domiciliary service, an innovation introduced in 1948, furnished 170 cases. This is largely a local service on which an increasing demand is made by local practitioners.

(4) Co-operation with general hospitals is shown by item 3 (172 admissions from psychiatric units of those hospitals), and by item 9 (74 admissions from non-psychiatric hospitals). Consultant psychiatrists not on the hospital staff (item 6) sent in 112 cases.

(5) The great majority of patients admitted through the out-patient department were referred to the hospital by general practitioners. But these sometimes send up emergencies which are admitted direct, without passing through the outpatient department. It will be seen (item 5) that 137 patients (4.2 per cent) were so admitted.

(6) Item 10 gives 41 patients as having been received from mental hospitals. These were admitted largely in connection with research projects. It should be remembered that today the majority of admissions to mental hospitals are voluntary admissions.

(7) As earlier remarked, no patient was admitted during the triennium without the approval of a member of the hospital's senior staff, and none came in otherwise than voluntarily.

It will be seen from table 22 that the referring agencies are tabulated in a descending order of the totals column.

The following points are noteworthy:

(1) The majority of outpatients (60.6 per cent) are referred to the hospital by general practitioners (item 1).

(2) Over a thousand of the total of 7,713 outpatients had been inpatients who were referred after discharge from the wards to the outpatient department for further supportive or other treatment (item 2). The total number of inpatients discharged during the triennium was 3,245. Of these 1,069, or 32.9 per cent—almost exactly a third—were referred to the outpatient department.

(3) Women (3,919) exceed men (3,794) by 125. The excess of women over men is most pronounced in the first two categories which are also the largest. General practitioners sent 358 more women than men, and among discharges from the wards, women exceeded men by 209—a total excess of 567 women. More women than men were also referred by general hospitals (non-psychiatric: item 5) and more were sent in from the domiciliary service. In most of the other groups, men exceed women, and the character of these other sources influences the diagnostic features of our male patients.

(4) Men exceed women in item 3 (spontaneous referrals), item 4 (probation service), item 7 (Labour Exchange), item 8 (Ministry of Pensions), item 10 (Public Assistance Institutions) and item 15 (ex-Services Welfare organisations). In these five groups taken together, men exceed women by 539. Compared with male patients referred

by general practitioners, these groups contain a large proportion of chronic neurotics and maladjusted psychopaths. Many male patients who visit the hospital spontaneously are ex-mental hospital patients, sometimes wandering at large.

(5) The total figure comprises the 1,819 patients mentioned in the preceding table as having been warded from the outpatient department. Hence the comments on the preceding table about co-operation with outside hospitals and consultants also apply here. The fact that a remand home is staffed by this hospital is reflected in item 4. If the first two items are discounted, patients referred from the probation service, remand homes, courts, etc., appear high on the list.

	Males and Females Combined		Males		Females	
	Nos.	%	Nos.	%	Nos.	%
1. General Practitioners ...	4,676	60.6	2,159	56.9	2,517	64.2
2. Ex I.Ps referred to O.P.D.	1,069	13.9	430	11.3	639	16.3
3. Spontaneous	318	4.1	181	4.8	137	3.5
4. Probation Service, Remand Home, Court, etc. ...	257	3.3	203	5.4	54	1.4
5. Non-psychiatric Hospital or department	225	2.9	91	2.4	134	3.4
6. Psychiatric Unit or Dept. of general hospital ...	182	2.4	84	2.2	98	2.5
7. Ministry of Labour & N.S. (Local Labour Exchange)	165	2.1	149	3.9	16	0.4
8. Ministry of Pensions ...	150	1.9	141	3.7	9	0.2
9. B/M Domiciliary Service	89	1.2	27	0.7	62	1.6
10. Assistance Institutions ...	72	0.9	61	1.6	11	0.3
11. Industrial Medical Officer	70	0.9	46	1.2	24	0.6
12. Consultant psychiatrist on B/M staff	48	0.6	27	0.7	21	0.5
13. Consultant psychiatrist *not* on B/M staff	36	0.5	13	0.3	23	0.6
14. Observation Ward ...	35	0.5	19	0.5	16	0.4
15. Ex - Services Welfare Organisations	35	0.5	33	0.9	2	0.1
16. Other voluntary organisations	31	0.4	15	0.4	16	0.4
17. Mental Hospitals ...	25	0.3	10	0.3	15	0.4
18. B/M Children's Dept. ...	23	0.3	4	0.1	19	0.5
Other referrals	209	2.7	102	2.7	107	2.7
Total referrals	7,715		3,795		3,920	
Number of Discharged patients involved in above referrals ...	7,713		3,794		3,919	

Table 22. Referring Agencies.

7,713 Outpatient Discharges.

4. Duration of Stay of Inpatients.

	Males		Females		Total	
	No.	%	No.	%	No.	%
Under a month	278	19.9	306	16.6	584	18.0
1–3 months	650	46.6	824	44.5	1,474	45.4
4–8 months	403	28.8	607	32.9	1,010	31.1
9–12 months	46	3.3	74	4.0	120	3.7
Over a year	20	1.4	37	2.0	57	1.8
Totals	1,397	100.0	1,848	100.0	3,245	100.0
Average Duration of Stay (months)	3.6		4.0		3.8	

Table 23. *Duration of Stay in Hospital.*

3,245 Inpatient Discharges.

(1) Females stayed about twelve days longer than men on the average.

(2) Patients were retained in hospital for over a year (57 patients) only for special reasons. The Medical Committee of the hospital reviews every quarter a list of patients so retained.

(3) The presence of these long-stay patients raises the average; the figures of average duration of stay are therefore misleadingly high for the majority of patients.

5. Number of Times Seen: Outpatients.

The number of times that outpatients are seen, as shown in Table 24, relates to a single admission. An admission to the outpatient department is defined in terms of the Joint Hospital's three-months' rule as described on page 33. The number of times that a patient is seen at each admission to the outpatient department should be clearly distinguished from the number of his previous admissions to that department.

It will be seen from table 24 that:

(1) The mean number of times that outpatients are seen by doctors is 3.1 (3.3 for men and 3.0 for women). But the very long tail to the distribution (78 patients were seen more than 25 times and 24 more than 50 times) has an effect on these figures which is out of proportion to the number of patients involved. If the 10.3 per cent of patients seen seven times and over are left out of account, the mean number of times seen is reduced to 1.8.

(2) But these figures should not be interpreted as denoting the

amount of attention that the hospital bestows on its outpatients. Thus it will be seen that 53.2 per cent of the 7,713 patients (namely 4,086 patients) were seen once only. But of these many were warded. A large majority of the 1,819 patients shown in table 21 as having been admitted to the wards from the outpatient department were put down for admission to the wards after being seen once only. If these, and also outpatients referred at their first attendance to other hospitals and residential institutions (table 29, page 45), are taken into account, the average number of attendances is raised. Attendances in the outpatient department are counted as such for purposes of this table only when a doctor is seen. Attendances for interview with psychologists and psychiatric social workers are not here counted; and physical treatments, with the exception of the administration of CO_2, are not conducted in the outpatient department.

No. of times seen	Percentages		
	Males (3,794)	Females (3,919)	Total (7,713)
Once	53.4	52.8	53.2
Twice	16.8	17.5	17.1
Three times	8.0	8.6	8.3
Four times	5.3	5.3	5.3
Five to six times	5.7	5.9	5.8
Seven times and over	10.8	9.9	10.3
Total	100.0	100.0	100.0
Average No. of times seen ...	3.3	3.0	3.1

Table 24. *Number of Times Seen.*

7,713 Outpatient Discharges: Percentages.

(3) Nevertheless, these figures bring out the fact that only a minority of psychiatric patients referred to the hospital for a consultant's opinion and/or treatment are regarded by the senior hospital staff as in need of prolonged psychotherapy involving many hospital attendances. Indeed, many think that numerous hospital attendances, making big demands both on doctor's and patient's time, may do more harm than good by implanting in the patient's mind the idea that his illness must be serious or by inculcating a mental habit of invalidism. The policy followed by the majority of the Joint Hospital's consultants who see outpatients is, when possible, to refer them back to their private doctors to whom an appropriate letter is written. The hospital does not encourage numerous return visits of outpatients at which the doctor spends a few minutes only with each patient and repeats supplies of one of the hospital's stock mixtures.

6. Special Investigations: Inpatients.

Order	Investigation	Percentages		Total Investigations
		Males	Females	
1	Wasserman or Kahn	86.1	83.9	2,755
2	Erythrocyte sedimentation test ...	83.3	85.5	2,746
3	Blood Count	46.7	65.1	1,856
4	Non-verbal intelligence tests ...	60.5	50.1	1,771
5	Verbal intelligence tests	59.6	50.4	1,763
6	Electro-encephalogram	35.4	22.8	917
7	X-Ray examinations	26.6	20.6	751
8	Cerebro-spinal fluid	12.5	6.7	297
9	Tests of Deterioration	12.4	7.0	302
10	Bacteriological Tests	6.8	7.6	236
11	Basal Metabolic Rate	3.2	4.8	135
12	Electro-cardiogram	4.9	3.4	131
13	Glucose tolerance and Insulin ...	3.5	2.8	101
14	Differential aptitude tests... ...	4.0	1.7	88
15	Gastric Analysis	1.4	1.8	52
16	(a) Other special Biochemical tests	58.2	62.8	1,992
	(b) Other special Psychological tests	4.4	3.4	123
	(c) Other Microscopical tests ...	3.9	2.5	100
	(d) Other tests	1.1	1.1	32

Note.—Percentages are of number of patients, namely, 1,397 males and 1,848 females.

Table 25. *Special Investigations.*
3,245 Inpatient Discharges.

The investigations as shown in table 25 are tabulated in descending order of frequency as shown in the totals column.

Table 25 provides a commentary on the use made for clinical purposes of special departments which, in addition to their activities in research and teaching, undertake the examination of patients. The departments in question form part of the Institute of Psychiatry. The hospital further contains the department of Clinical Pathology which is responsible for much investigation of patients. In addition to the activities above summarised, which concern inpatients, much work is also done by special departments for the larger number of outpatients, though investigations for these are not asked for as a routine. The following points may be noted.

(1) Items 1, 2, 3, 8, 13 and 15 concern the Department of Pathology. The total number of tests here comprised is 7,807.

(2) Items 4, 5, 9, 14 and 16 (b) concern the Department of Psychology, which has performed 4,047 tests of a miscellaneous character. These tests, unlike those carried out by the Department of Pathology, involve contacts with individual patients and some take a long time, amounting to two hours, to administer. In addition, special coaching has sometimes been undertaken by this

department, as, for example, of patients with reading defects. A therapeutic function is thus added to the diagnostic.

(3) The department of Electro-encephalography (item 6) has played a notable part in the hospital's clinical work. Here again contact with patients is involved.

7. Special Treatments.

Special Treatment (Multiple Treatments included)	Males (1,397)		Females (1,848)		Total (3,245)	
	No.	%	No.	%	No.	%
(a)	(b)	(c)	(d)	(e)	(f)	(g)
1. E.C.T. and Electro-narcosis	272	19.4	653	35.3	925	28.5
2. Special Drug Treatment ...	235	16.7	256	13.7	491	15.1
3. Deep Insulin	86	6.1	112	6.2	198	6.1
4. Modified Insulin	53	3.8	141	7.5	194	5.8
5. Drug Abreaction	43	3.1	71	3.8	114	3.5
6. Continuous Narcosis ...	10	0.7	25	1.4	35	1.1
7. Leucotomy	4	0.3	30	1.6	34	1.1
8. Hypnosis	8	0.6	17	0.9	25	0.8
9. Group Therapy	5	0.4	15	0.8	20	0.6
10. G.P.I. Treatment	10	0.7	3	0.2	13	0.4
11. Total patient-treatments ...	726		1,323		2,049	
12. Total patients treated ...	619	44.3	1,055	57.1	1,674	51.6
13. Patients who received no special treatment	778	55.7	793	42.9	1,571	48.4
14. Totals	1,397	100.0	1,848	100.0	3,245	100.0

Table 26. *Special Treatments.*
3,245 Inpatient Discharges.

It will be seen from table 26 that:

(1) Ten forms of special treatment are listed which include multiple treatments of the same patients. It will be seen (column f) that 1,674 patients received 2,049 special treatments.

(2) Of the 3,245 inpatients, 48.4 per cent (column g) received no special treatment. The term "special treatment" should here be understood. It will be seen that, with the exception of items 8 and 9 which comprise but 45 patients, physical treatments only are here comprised. There has been much controversy in recent years about the medical and moral aspects of certain forms of physical treatment, particularly of leucotomy. The Joint Hospital's policy in this matter is conservative compared with that of some hospitals. All inpatients are fully investigated both from the medical and social standpoints, and their problems fully discussed. All receive some measure of psychotherapy, and in this sense all are treated,

though not necessarily by physical means. The hospital does not give E.C.T. to outpatients.

(3) More females than males received special treatments—57.1 compared with 44.3 per cent (line 12). The excess is mainly accounted for by the more extensive use of ECT and Electro-narcosis for females than males. More females also were treated by modified insulin. Relatively more males than females, on the other hand, received special drug treatments (item 2).

(4) It will be seen that leucotomy (item 7) was sparingly used. Every patient for whom leucotomy is proposed is considered at a special conference and conservative standards are adopted. Thirty-four patients were so treated, thirty being women.

(5) Twenty patients (item 9) were treated while inpatients by group therapy. But this figure should not be taken as an index of the practice of group therapy in the Joint Hospital. Group therapy is more applicable to outpatients and is systematically used for them.

(6) The distribution of "special treatments" by diagnosis is shown in Chapter 4, page 71.

8. Outcome of Treatment.

Condition when discharged	Males (1,397)	Females (1,848)	Total (3,245)
1. Recovered or much improved (1,539)	42.4	51.3	47.5
2. Improved or slightly improved (974)	31.4	29.0	30.0
3. No change, worse, died or suicide (732)	26.2	19.7	22.5
Totals (3,245)	100.0	100.0	100.0

Table 27. Outcome of Treatment.
3,245 Inpatient Discharges.

It will be seen from table 27 that:

(1) More than three-quarters of the patients benefit; just under a half leave hospital recovered or much improved; between a quarter and a fifth do not benefit.

(2) Results of treatment are a little better for women than men. Over half the former leave hospital recovered or much improved and under a fifth do not benefit. The difference (as shown in table 32 below) is mainly due to the larger number of women than men (693 against 384) treated for depressions (numbers 301 and 314 in the Diagnostic list), which have a relatively favourable prognosis. Just under 70 per cent of these 693 women left hospital recovered or much improved. See also table 52, page 72.

(3) Deaths (33) and suicides (three: all males) constitute but a small fraction of the third group.

(4) The assessment of outcome is a qualitative judgment wherein there is no external yardstick. There are possibilities of ambiguity. A manic-depressive patient may be discharged as recovered for the time being, though further depressive attacks may be fairly confidently expected. The immediate outcome of treatment and the long-term prognosis may be at variance.

Though uniformity of standards is difficult to attain, the Joint Hospital's tradition favours caution. No attempt is made through the systematic analysis of data on the front page to assess the outcome of outpatient treatment.

9. Disposals.

A. Inpatients.

Disposals (multiple)	Percentages		
	Total (3,245)	Males (1,397)	Females (1,848)
A. 1. To Private Doctor	32.0	30.5	33.2
B. *Further treatment or supervision at Joint Hospital.*			
2. To outpatient dept. for further treatment or supervision ...	56.1	52.8	58.6
3. For follow-up by P.S.W. ...	3.6	3.4	3.7
4. To clinic for epilepsies ...	2.7	3.6	2.1
	62.4	59.8	64.4
C. *For residential treatment outside.*			
5. Admission to observation ward recommended	4.3	4.2	4.3
6. Admission to mental hospital recommended	2.3	3.1	1.7
7. Admission to non-mental hospital recommended ...	2.3	2.3	2.3
8. Admission to residential institutions recommended	1.5	1.4	1.5
9. Admission to other psychiatric unit recommended	0.5	0.6	0.5
	10.9	11.6	10.3
D. 10. Other Disposals	13.1	15.4	7.8
E. 11. Discharged against advice ...	13.8	13.7	13.9

Total Disposals: 4,228 (Males 1,853, Females 2,375) of 3,245 patients. (The disposals being multiple, the percentages exceed 100).

Table 28. *Disposals.*

3,245 Inpatient Discharges.

(1) In table 28, five main categories of disposal are shown, namely (A) to the patient's private doctor, (B) for further supervision or treatment at the Joint Hospital, (C) for residential treatment (hospital or institution) outside, (D) other disposals, and (E) discharges against advice.

(2) Just under a third (32.0 per cent) of patients are shown as being referred to their private doctors. But this figure covers only those patients for whom no other main disposal is made. To every doctor who has been in any way concerned with a patient's admission, a letter is written when his patient is discharged.

(3) Just under two-thirds (62.4 per cent) of patients are referred for further treatment at, or follow-up by, the Joint Hospital. More women than men are so referred (64.4 against 59.8 per cent).

(4) Eleven per cent of patients are recommended for other residential treatment or accommodation after discharge. Relatively more males than females are recommended for admission to a mental hospital (3.1 compared to 1.7 per cent).

(5) Among "Other disposals" (item 10) are included 2.3 per cent of patients who are referred to the Disablement Resettlement Officer (D.R.O.) with whom the hospital works closely.

B. Outpatients.

Disposals (Multiple)	Percentages		
	Totals (7,713)	Males (3,794)	Females (3,919)
A. 1. Referred to Private Doctor ...	35.1	32.7	37.4
B. Admission to Hospital or Institution recommended.			
2. Admitted to Joint Hospital ...	22.6	20.6	24.5
3. Admission to Mental Hospital as V.P. recommended	5.7	5.5	5.9
4. Admission to Observation Ward recommended	3.0	2.3	3.7
5. Other Residential treatment recommended	2.7	2.8	1.9
	34.0	31.2	36.0
C. Other			
6. No special disposal	20.6	20.7	20.5
7. Other Disposals	12.1	17.0	7.2
	32.7	37.7	27.7
The disposals being multiple, the percentage exceed 100.			

Table 29. Disposal.

7,713 Outpatient Discharges.

(1) It will be seen from table 29 that three main categories of about equal size appear: (A) just over a third of patients (35.1 per cent) are referred back to their private doctors; (B) about a third (34.0 per cent) are either admitted to the joint hospital or recommended for admission to another hospital or institution; (C) just under a third (32.7 per cent) are not specially disposed of or are disposed of in other ways.

(2) It may seem that the number (35.1 per cent) referred back to the private doctor is unduly small seeing that a majority (61 per cent: table 22) of patients referred to the outpatient department are referred by private doctors. But allowance needs to be made for the fact that 19.3 per cent of patients are counted as having lapsed with the result that no disposal could be made. If tables 29 and 31 are compared, it will be seen that the percentages of patients who lapsed and of those for whom no disposals are made, are closely similar, amounting to about a fifth of the total. Allowance (in assessing the number of patients referred back to their private doctors) has further to be made for the fact that 34 per cent of patients are disposed of by being admitted to the Joint Hospital's wards or by being recommended for admission elsewhere; and that, comprising item 7 (other disposals) are recommendations to the probation service, to remand homes and prisons, to government departments, and to outside psychiatrists. All practitioners who refer patients to the Joint Hospital are as a routine informed of the step taken or recommended.

10. Mode of Leaving.

Inpatients who discharge themselves against advice.

Between one patient in seven and one in eight (13.8 per cent) discharges himself against advice.

Males (1,397)		Females (1,848)		Totals (3,245)	
Nos.	%	Nos.	%	Nos.	%
191	13.7	257	13.9	448	13.8

Table 30. *Inpatients discharging themselves against advice.*
3,245 Discharges.

Patients who discharge themselves against advice commonly present difficult administrative problems calling for immediate solution when they are acutely ill. It will be seen from table 30 that there is no difference between the proportion of male and female patients who discharge themselves against advice. These are examined by diagnosis in table 58 below.

The proportion (13.8 per cent) is lower than that of patients who lapse (19.3 per cent). The two groups are comparable in that in different ways they represent failures of treatment.

Lapses among outpatients.

Mode of Leaving	Percentages		
	Males (3,794)	Females (3,919)	Totals (7,713)
Discharged	79.1	81.7	80.5
Lapsed	20.5	18.1	19.3
Died	0.2	0.1	0.1
Suicide	0.3	0.1	0.1
Totals	100.0	100.0	10.00

Table 31. *Lapses among* 7,713 *Outpatients Discharged.*

(1) Deaths and suicides which occurred outside hospital while the patient was attending the outpatient department, thus closing his case, are here counted as a mode of leaving. Ten patients died and nine committed suicide. Patients admitted from the outpatient department to the wards of the Joint Hospital or to other hospitals are formally discharged from the outpatient department, often to be readmitted again later.

(2) It will be seen from table 31 that nearly a fifth (19.3 per cent) of outpatients lapsed. A patient is counted as lapsed if, an appointment having been made for him to attend the outpatient department, he does not do so, does not notify the hospital, and makes no subsequent effort to make contact. Most of these patients fail to attend because they do not think it worth their while. The matter is dealt with in terms of diagnosis in table 59 below. It may here be noted that the largest proportion of lapsed cases are among those being treated for sexual deviations (though their total number is small). Patients diagnosed as pathological or immature personalities—many of the former being offhand and casual in their habits —also rank high. So do patients suffering from anxiety.

Lapses among outpatients are perhaps comparable with discharges against advice among inpatients which (table 30) amount to 13.8 per cent of all inpatients. Most of both groups can be counted as failures of treatment.

11. Social Case Work Undertaken.

Of 3,325 inpatients social work was undertaken for 1,452 or 44.7 per cent; and of 5,480 outpatients for 972 or 17.7 per cent.

CHAPTER FOUR

DIAGNOSIS.

1. Arrangement of Chapter.

The problem of diagnosis, and in particular the use of a satisfactory system of psychiatric classification, is discussed at some length on pages 6-10. What follows should be understood in the light of what is there said.

In the ensuing tables, the arrangement adopted in the two preceding chapters is followed.

First, the hospital population will be shown by diagnosis. Total numbers (in- and outpatients combined) are presented in four-point and nineteen-point classifications; inpatients in nineteen- and twelve-point classifications; and outpatients in the nineteen-point classification. In- and outpatients are differently assorted as to diagnosis in the sense that the first is a selected sample and the second a relatively unselected group. The distribution by diagnosis of outpatients throws some light on the nature of the psychiatric problems with which general practitioners in Greater London have to deal.

All the above classifications are based on section five (shown in the Appendix) of the World Health Organisation's *International Classification*. It will be seen from Table 36 below (page 56) that, of the total hospital population of 8,725 patients dealt with over the triennium, 835 patients, or 9.6 per cent of the total, were given diagnoses which fall outside the above mentioned section five (Appendix). These patients have been assigned to a Miscellaneous" group shown at the bottom of each of the comprehensive tables. This substantial minority of patients is discussed in some detail. All these tables are based on the *Principal Disease* as defined in the Ministry of Health's instructions (see page 9).

In Chapter One (page 8), mention is made of a supplementary list of *Principal Accessory Chronic Conditions*. This list was there discussed in order to illustrate some of the special difficulties of diagnosis in psychiatry and in particular the frequent insufficiency of a single diagnostic label. This supplementary list is examined from other standpoints in the following pages.

Chapter Two, above, deals under twelve headings with the demographic, social and economic features of the Joint Hospital's population. It was not worth while to prepare diagnostic breakdowns of all these eleven items. Three only are so treated in the present chapter, namely age, marital status, and fertility.

Chapter Three, above, discusses (in chronological order) eleven features arising from the contact which a patient makes with the hospital, beginning with the events relating to his admission and ending with those connected with his mode of leaving. A similar

chronological order is observed below. Of the eleven events discussed in Chapter Three, eight are here further examined in the light of diagnosis, namely the number of previous admissions or receptions to the wards and outpatient department, the number of admissions from the outpatient department to the wards of the Joint Hospital, the duration of stay of inpatients, the number of times that outpatients are seen in the course of a single period of admission (number of attendances), the special treatments given to inpatients when in the wards, the outcome of treatment of inpatients, the disposal of inpatients and, lastly, the mode of leaving. Special attention is paid to the proportions in each diagnostic group of inpatients who discharge themselves against advice and of outpatients who lapse—e.g. those who fail to keep appointments without notifying the hospital or later communicating with it.

2. Psychiatric Lists and Classifications.

The nineteen-point classification, which was described in Chapter One, is a condensation of the 76-point list contained in Section Five of the *International List of Diseases and Causes of Death* and reproduced in the Appendix.

The following is the distribution of 3,245 inpatients according to this list.

Code Nos.	Diagnostic Group	Males		Females		Totals	
		Nos.	%	Nos.	%	Nos.	%
300	Schizophrenic disorders	232	16.6	257	13.9	489	15.0
301	Manic - depressive reaction ...	218	15.6	352	19.0	570	17.5
303	Paranoia & paranoid states	17	1.2	22	1.2	39	1.2
304, 306	Seniles psychoses and psychoses with cerebral arteriosclerosis	31	2.2	45	2.4	76	2.3
305, 307, 308.0, 308.2	Organic disorders of the central nervous system	43	3.2	25	1.4	68	2.1
308.1	Psychosis resulting from epilepsy ...	6	0.4	7	0.4	13	0.4
302, 309	Other psychoses ...	46	3.3	149	8.1	195	6.0
310	Anxiety	120	8.6	125	6.8	245	7.5
311	Hysteria	41	2.9	133	7.2	174	5.5
313	Obsessive - compulsive reaction ...	50	3.6	49	2.6	99	3.1
314	Neurotic depressive reaction	166	11.9	341	18.5	507	15.6
312, 315–18	Other psychoneuroses	61	4.4	76	4.1	137	4.2
320, 321	Pathological and immature personalities	113	8.1	77	4.2	190	5.9
320.6	Sexual deviations ...	15	1.1	4	0.2	19	0.6
320.7	Non-sexual delinquancy	7	0.5	2	0.1	9	0.3
322, 323	Alcoholic and drug addiction ...	59	4.2	18	1.0	77	2.4
324	Primary childhood disorders	8	0.5	4	0.2	12	0.4
325	Mental deficiency ...	3	0.2	5	0.2	8	0.2
Miscellaneous (outside Nos. 300–326)		161	11.5	157	8.5	318	9.8
Total		1,397	100.0	1,848	100.0	3,245	100.0

Table 32. Distribution of 3,245 Inpatient Discharges by Diagnosis.

Nineteen Groups numbered as in International Classification.

It will be seen that in ten of the nineteen diagnostic groups shown in table 32 the total figures fall below 100, and are therefore of little use for comparison though they are of interest on other grounds. A twelve-point list, in some ways more convenient than the nineteen-point, is given below (table 33). It is arranged in a descending order of total figures which exceed 100. Of these there are ten; and two other figures are added (for obsessional neurosis and for alcoholic and drug addictions) which, though smaller than a hundred, are of interest because they denote well-defined clinical types.

Diagnostic Group	Males		Females		Totals	
	Nos.	%	Nos.	%	Nos.	%
1. Manic-depressive reactions	218	15.6	352	19.0	570	17.5
2. Neurotic depressive reactions	166	11.9	341	18.5	507	15.6
3. Schizophrenia	232	16.6	257	13.9	489	15.0
4. Anxiety	120	8.6	125	6.8	245	7.5
5. Other psychoses	46	3.3	149	8.1	195	6.0
6. Pathological and immature personalities	113	8.1	77	4.2	190	5.9
7. Hysteria	41	2.9	133	7.2	174	5.5
8. Other psychoneuroses ...	61	4.4	76	4.1	137	4.2
9. Obsessive-compulsive reaction	50	3.6	49	2.6	99	3.1
10. Alcoholic and other addictions	59	4.2	18	1.0	77	2.4
11. Other psychiatric conditions within the code-numbers 300–325 ...	130	9.3	114	6.1	244	7.5
12. Miscellaneous: Outside code numbers 300–325...	161	11.5	157	8.5	318	9.8
Totals	1,397	100.0	1,848	100.0	3,245	100.0

Table 33. *Distribution of* 3,245 *Inpatient Discharges by Diagnosis.*

Twelve Groups.

It will be seen from table 33 that the two depressive reactions, head the list. They comprise 1,077 of the 3,245 inpatients or nearly a third (33.1 per cent) of the total. The proportion of women (37.5 per cent) appreciably exceeds that of men (27.5 per cent). Fifteen per cent of the total are schizophrenics, men slightly exceeding women in the proportions.

Table 34 shows the distribution by diagnosis of the 7,713 Outpatient Discharges.

A comparison between tables 32 and 34 shows a different distribution of diagnostic groups between in- and outpatients; it therefore throws light on how inpatients are selected.

Diagnostic Group	Males		Females		Totals	
	Nos.	%	Nos.	%	Nos.	%
Schizophrenic disorders ...	327	8.6	288	7.3	615	8.0
Manic-depressive reaction ...	291	7.7	508	13.0	799	10.3
Paranoia and paranoid states...	38	1.0	38	1.0	76	1.0
Senile psychoses	51	1.4	93	2.4	144	1.9
Organic disorders of the Central nervous system ...	23	0.6	20	0.5	43	0.6
Psychosis resulting from epilepsy	6	0.2	6	0.2	12	0.2
Other psychoses	65	1.7	224	5.7	289	3.7
Anxiety	631	16.6	549	14.0	1,180	15.3
Hysteria	134	3.5	287	7.3	421	5.5
Obs. comp. reaction	111	2.9	115	2.9	226	2.9
Neurotic depressive reaction ...	420	11.1	764	19.5	1,184	15.3
Other psychoneuroses... ...	266	7.0	264	6.7	530	6.8
Pathological and immature personality	484	12.8	225	5.7	709	9.2
Sexual deviations	174	4.6	6	0.2	180	2.3
Non-sexual delinquency ...	51	1.3	18	0.5	69	0.9
Alcoholic and drug addictions	99	2.6	32	0.8	131	1.7
Primary childhood disorders	10	0.3	11	0.3	21	0.3
Mental deficiency	65	1.7	40	1.0	105	1.4
Miscellaneous: Diagnosis outside Code Numbers 300–325	548	14.4	431	11.0	979	12.7
Totals	3,794	100.0	3,919	100.0	7,713	100.0

Table 34. *Distribution of* 7,713 *Outpatient Discharges by Diagnosis.*

Nineteen Groups.

It will be seen that inpatients are throughout better represented in groups 300—309 (psychoses); all the percentages are higher in table 32 than in table 34 with the exception of those for females with senile psychoses and cerebral arteriosclerosis of whom the proportion among in- and outpatients is the same (2.4 per cent).

In respect of psychoneuroses (rubrics 310—318), the picture is different. Patients with anxiety are relatively twice as numerous among out- as among inpatients (15.3 against 7.5 per cent). But hysterics, obsessive-compulsives and neurotic depressives are about equally represented.

Patients with disorders of behaviour, character and intelligence (rubrics 320—326) are all better represented among outpatients except alcoholics and drug addicts. It was mentioned above that these are not given special treatments as outpatients.

Diagnostic Assortment and rubrics.	Males			Females			Totals		
	Mental Hosp. 23,596	B/M I.P.s 1,397	B/M O.P.s 2,836	Mental Hosp. 32,189	B/M I.P.s 1,848	B/M O.P.s 2,644	Mental Hosp. 55,785	B/M I.P.s 3,245	B/M O.P.s 5,480
Psychoses 300–309	65.6	42.4	17.5	74.2	46.4	26.2	70.6	44.5	21.7
Psycho-Neuroses 310–318	14.9	31.4	44.5	14.7	39.2	55.2	14.7	35.9	49.6
Disorders of Character, etc. 320–326 ...	7.7	14.7	27.5	3.5	5.9	10.3	5.3	9.8	19.2
Miscellaneous	11.8	11.5	10.5	7.6	8.5	8.3	9.4	9.8	9.5
Totals	—100.0—								

Mental Hospital=55,785 Direct Admissions to *Mental* Hospitals in England and Wales during 1949. (Registrar-General's *Statistical Review (1953) for the year 1949. Supplement on General Morbidity, Cancer, and Mental Health, page 75)*

Joint Hospital: Inpatients=3,425
Joint Hospital: Outpatients=5,480

Table 35. *Percentage Distribution of Patients in Four Major Diagnostic Assortments. Comparison of Admissions to Mental Hospitals of England and Wales,* 1949, *with Joint Hospital's In- and Outpatient Discharges.*

A simple comparison of the distribution by diagnosis of in- and out patients is afforded by the four-point classification shown in table 35. This table compares the percentages, in four major diagnostic assortments, of admissions to mental hospitals in England and Wales during 1949 (conveniently supplied in 1953 by the Registrar General in a supplement dealing with morbidity, cancer and mental health) with the Joint Hospital's in- and out-patients during the triennium of which the first year was 1949.

It will be seen from table 35 that the figures for the Joint Hospital's inpatients are intermediate between those for outpatients and for admissions to mental hospital. Among the latter psychoses conspicuously preponderate and by comparison with them psychoneuroses and disorders of character, etc., are poorly represented. Among the Joint Hospital's outpatients, psychoses number just over a fifth (21.7 per cent), psychoneuroses a half (49.6 per cent) and disorders of character, etc., a fifth (19.2 per cent). The figures for Joint Hospital inpatients are throughout intermediate between the other two. The selection of the Joint Hospital's inpatients from its outpatients is therefore subject to a bias generally similar to that affecting the selection of people from the general population for admission into mental hospitals, but the bias is much less pronounced.

In the above comparison, the Joint Hospital's patients are related to those of mental hospitals. By another comparison the Joint Hospital's inpatient discharges can be related to inpatient discharges from teaching and general hospitals.

A hospital Morbidity Survey published by the General Register Office (G.R.O. *Studies on Medical and Population Subjects,* No. 4, 1951) gives figures for some 147,000 discharges during the first six months of 1949 from an assortment of London and Provincial Teaching Hospitals and from hospitals under two Regional Boards which participated in the survey. (Included in these figures are 277 patients discharged from the Joint Hospital).

The great majority of discharges from teaching and general hospitals are naturally of patients suffering from physical illnesses which, in the tables shown in this triennial report, are comprised in the "Miscellaneous" group. In the G.R.O's Morbidity Survey, however, a total of 1,536 patients were psychiatric cases which are classified under rubrics 300—326.

It is in accordance with expectation that these 1,536 patients, discharged after treatment for psychiatric illnesses from teaching and general hospitals, comprised fewer psychotic and more psychoneurotic cases than do the Joint Hospital's discharged inpatients as shown in table 35. If the Miscellaneous cases (numbering 318) are omitted from the Joint Hospital's total of 3,245 inpatients, the percentage in the three main assortments compare as follows with those shown by the Morbidity Survey:

Major Assortments	Joint Hospital		Morbidity Survey	
	No.	%	No.	%
Psychoses 300–309... ...	1,450	49.5	415	27.0
Psycho-neuroses 310–318...	1,162	39.7	958	62.4
Disorders of Character, etc. 320–326	315	10.8	163	10.6
Total	2,927	100.0	1,536	100.0

Table 35a. *Distribution in three major Assortments of Discharges of Joint Hospital Inpatients compared with Discharges from Teaching and General Hospitals* (1949).

It will be seen from table 35a that half the Joint Hospital's discharges were psychotic cases compared to 27 per cent of those covered by the morbidity survey; that psychoneurotic patients were correspondingly more numerous in the Morbidity Survey (62.4 compared with 39.7 per cent); and that the proportion of patients with disorders of character, etc., was the same—just over a tenth—in both. As remarked above, the 1,536 psychiatric discharges recorded in the Morbidity Survey included 277 cases (18 per cent) discharged from the Joint Hospital. If these 277 cases were subtracted from the total (a procedure which the figures given in the Morbidity Survey do not permit), the differences between the figures under the two headings would have been slightly more pronounced than as shown in Table 35a.

As mentioned in Chapter One, the Joint Hospital's teaching duties require that patients with a wide variety of psychiatric illnesses—some of them acutely ill, but none certified—be admitted to the wards. For the treatment as inpatients of such acute cases the Joint Hospital has facilities which are not available in most teaching or general hospitals, despite the fact that many of these have active psychiatric departments.

Table 36 shows the distribution by diagnosis of the total number of both in- and outpatient discharges throughout the triennium. Here are comprised all the patients shown in Tables 32 and 34.

Diagnostic Group	Males		Females		Totals	
	Nos.	%	Nos.	%	Nos.	%
Schizophrenic disorders ...	451	10.7	424	9.6	875	10.0
Manic-depressive reaction ...	375	8.9	640	14.2	1,015	11.6
Paranoia and paranoid states...	43	1.0	51	1.1	94	1.1
Senile psychoses and psychoses with cerebral arteriosclerosis	69	1.6	126	2.8	195	2.2
Organic disorders of the C.N.S.	57	1.3	40	0.9	97	1.1
Psychosis resulting from epilepsy	10	0.2	9	0.2	19	0.2
Other psychoses	84	2.0	261	5.8	345	4.0
Anxiety	655	15.5	578	12.9	1,233	14.1
Hysteria	159	3.8	344	7.7	503	5.8
Obsessive-compulsive reaction	129	3.1	119	2.6	248	2.8
Neurotic depressive reaction ...	463	10.9	850	18.9	1,313	15.1
Other psychoneuroses ...	294	6.9	291	6.5	585	6.7
Pathological and immature personalities	548	13.0	257	5.7	805	9.2
Sexual deviations	177	4.2	10	0.2	187	2.1
Non-sexual delinquency ...	57	1.3	19	0.4	76	0.9
Alcoholic and drug addictions	119	2.8	37	0.8	156	1.8
Primary childhood disorders ...	16	0.4	15	0.3	31	0.4
Mental deficiency	68	1.6	45	1.0	113	1.3
Miscellaneous: Diagnoses outside code Nos. 300–326 ...	459	10.8	376	8.4	835	9.6
Totals	4,233	100.0	4,492	100.0	8,725	100.0

Table 36. *Distribution of* 8,725 *In- and Outpatient Discharges by Diagnosis.*

Nineteen Groups.

Table 37 shows the same four-point classification as that of table 35.

Code Number and Diagnostic Assortment	Males		Females		Totals	
	No.	%	No.	%	No.	%
300–309 Psychoses	1,089	25.7	1,551	34.6	2,640	30.2
310–318 Psycho-neuroses ...	1,700	40.2	2,182	48.6	3,882	44.5
320–325 Disorders of character etc.	985	23.3	383	8.4	1,368	15.7
Miscellaneous	459	10.8	376	8.4	835	9.6
Totals	4,233	100.0	4,492	100.0	8,725	100.0

Table 37. *Distribution of* 8,275 *In- and Outpatient Discharges by four Major Diagnostic Assortments.*

Three in ten patients were diagnosed as having psychoses; five out of eleven as having psychoneuroses; and about one in six as having disorders of character. More females than males fall into the first two groups, and many more males than females into the third. It is the general experience, clearly shown in the Registrar General's figures (table 35), that more men than women are assigned to this group.

"MISCELLANEOUS" GROUP.

It will be seen from table 36 that 835 patients (9.6 per cent of the total) were assigned to a "Miscellaneous" group, having received diagnoses outside section five of the *International Classification* (Appendix). These 835 patients fell into 96 diagnostic groups; but three quarters (76 per cent) were concentrated in eleven of these groups as shown in table 38:

Code No.	Diagnosis	Males	Females	Total
353	Epilepsy	77	56	133
326	Disorders of unspecified character ...	37	30	67
688	Complications of the puerperium ...	—	52	52
083	Late effects of encephalitis lethargica	20	14	34
780	Symptoms referable to the nervous system	17	11	28
025	G.P.I.	22	3	25
345	Multiple Sclerosis	3	16	19
354	Migraine	13	7	20
355	Other Diseases of the Brain	11	3	14
	Diagnosis uncertain	77	51	128
	No Psychiatric Abnormality	66	50	116
	Total (11 Groups)	343	293	636
	Remainder distributed over 85 Diagnostic groups	116	83	199
	Total (96 Groups)	459	376	835

Table 38. *"Miscellaneous" Cases distributed in* 96 *Diagnostic Groups*: 835 *In- and Outpatient Discharges.*

The last two of the eleven groups shown in table 38 ("Diagnosis Uncertain" and "No Psychiatric Abnormality") and the first (epilepsy) call for explanation. Some consultants do not enter a diagnosis until they discharge their patients. It was noticed (table 31) that, in terms of their "mode of leaving", 19.3 per cent of the 7,713 patients who passed through the outpatient department were counted as having lapsed. The "uncertain diagnosis" mainly relates to these. The 116 patients recorded as having no psychiatric abnormality form a composite group wherein problems of marital adjustment are prominent. Doctors, moreover, referred

a few patients who were troubled with complicated personal problems, sometimes concerning persons other than themselves, in the solution of which it was thought that the hospital could help. These patients are not always suffering from a mental illness. The first item in the table relates to 133 cases of epilepsy. Epilepsy also appears within the code numbers 300—326 with which we are mainly concerned. The item is numbered 308.1 and is worded "psychosis resulting from epilepsy and other convulsive disorders" (See Appendix). The emphasis here is on the accompanying psychosis. When this is absent, the patient is assigned the code number 353.

PRINCIPAL ACCESSORY CONDITIONS AND COMPLICATIONS.

It was mentioned in Chapter One (pages 8 and 9), that, in addition to the diagnosis of a *Principal Disease*, the Ministry of Health had asked all hospitals to enter, when appropriate, a supplementary diagnosis of *Principal Accessory Chronic Conditions*. A minority of our patients were recorded as suffering from such complications and accessory conditions. They numbered 1,841 or 21 per cent of the total of 8,725 discharges.

But as was to be expected, the range of these conditions was wider than that of the Principal Diseases of which a diagnosis was required in every case. Complications and Accessory Conditions were comprised in 203 Diagnostic Groups, Principal Diseases in 131.

As mentioned in Chapter One, these complicating and accessory illnesses illustrate some of the difficulties of making a psychiatric diagnosis. The following table shows their distribution according to the four-point classification shown in table 35.

Major Assortments	Males	Females	Total
1. 300–309 (Psychoses 10 diagnostic groups)	50	68	118
2. 310–318 (Psychoneuroses 10 groups)	295	366	661
3. 320–326 (Disorders of character, etc. 13 groups)	329	242	571
	674	676	1,350
4. Any number outside the series 300–326 (170 groups)	240	251	491
Totals (203 diagnostic groups) ...	914	927	1,841

Table 39. *Principal Accessory Chronic Conditions.*

1,841 Discharges distributed among 203 Diagnostic Groups: Four Major Assortments.

In table 39, the conditions in question have been assigned to the four major assortments shown in table 35. The fourth comprises all diagnoses which fall *outside* rubrics 300—326 which are concerned with psychiatry. Here are covered 491 of the total

of 1,841 patients (27 per cent); these are thinly spread over a wide range of conditions which fall into 170 diagnostic groups. They include poisonings, fractures, lacerations and other injuries, miscellaneous infections, hypertension and other diseases of the heart and arteries, diseases of the alimentary and respiratory tracts, skin diseases, blindness and deafness, anaemias, migraine, epilepsy and other miscellaneous diseases.

The remainder of the 1,841 cases fall within the rubrics 300—326 (Appendix) and are concerned with psychiatric conditions. These are regarded as in one way or another complicating, or accessory to, the primary diagnosis which, as already said, falls within the same (psychiatric) series in over ninety per cent of cases. It will be seen from table 39 that the 1,350 cases included within rubrics 300—326 are divided into three assortments numbered 1, 2 and 3, which respectively deal with psychoses, psychoneuroses, and disorders of character, behaviour and intelligence. It is not surprising that, among the psychoses, there are comprised the smallest number of cases, namely 118 (females outnumbering males); for psychoses, when present, are likely to be treated as the principal disease rather than as an accessory condition. Among the psychoses the four diagnostic groups shown in table 40 contain most patients:

Code No.	Diagnosis	Males	Females	Total
301	Manic Depressive reaction	13	21	34
303	Paranoid states	10	14	24
300	Schizophrenia	5	11	16
308.2	Other and unspecified psychosis ...	5	8	13

Table 40. *Principal Accessory Chronic Conditions comprised within Rubrics* 300—309.

87 Discharges.

The next assortment (rubrics 310—318) comprising psychoneuroses, is the largest. It includes 661 patients (table 39) and again females outnumber males. Among the psychoneuroses the four diagnostic groups shown in table 41 contain most patients:

Code No.	Diagnosis	Males	Females	Total
314	Neurotic Depression	82	109	191
311	Hysteria	31	78	109
313	Obsessive-compulsive neurosis ...	51	53	104
310	Anxiety	59	36	95

Table 41. *Principal Accessory Chronic Conditions comprised within Rubrics* 310—318.

499 Discharges.

The last assortment (rubrics 320—326) embracing disorders of character, etc., is also relatively large. The diagnostic groups in this assortment shown in table 42 contain most patients:

Code No.	Diagnosis	Males	Females	Totals
321	Immature Personality	56	81	137
320.3	Inadequate Personality	73	38	111
325	Mental Deficiency	33	34	67
320.6	Sexual Deviation	42	11	53
322	Alcoholism	40	13	53

Table 42. *Principal Accessory Chronic Conditions comprised within Rubrics* 320—326.
421 Discharges.

It will be seen that easily the largest of the diagnostic groups shown in tables 39—42 is No. 314, Neurotic Depression (191 cases: table 41); and that the next largest is No. 321, Immature Personality (137 cases: table 42); in both these groups, females outnumber males. The third largest group, No. 320.3, Inadequate Personality (111 cases: table 42), contains nearly twice as many males as females. Hysteria (109 cases: table 41) follows with more than twice as many females as males. These differences in incidence between the sexes are in accordance with clinical expectation; so is the pronounced excess of males over females among sexual deviants and alcoholics (table 42).

Diagnostic Group	Males		Females	
	No.	Avge. age	Avge. age	No.
Sexual Deviation	177	30.7	29.7	10
Schizophrenia	451	30.8	34.8	424
Pathological and immature personalities	548	31.2	31.4	257
Obsessive compulsive neurosis ...	129	33.2	34.7	119
Anxiety	655	33.7	34.3	578
Other psychoneuroses	294	35.7	35.5	291
Hysteria	159	35.7	30.7	344
Miscellaneous	459	37.4	38.3	376
Neurotic depression	463	39.0	37.6	850
Alcoholism and drug addiction ...	119	43.5	44.6	37
Manic-depressive reaction	375	47.2	46.1	640
Other psychoses	84	55.0	53.7	261
Senile psychoses	69	64.5	64.8	126
Totals	3,982	37.2	39.2	4,313

Table 43. *Age by Diagnosis.*
8,295 In- and Outpatient Discharges in Thirteen Diagnostic Groups.

There is doubtless much difference between consultants in the way they interpret such terms as immature and inadequate personality; and there is probably as much difference in the degree to which they supplement the primary diagnosis with another under the heading of an accessory chronic condition. Some might regard a personality that was in some sense immature or inadequate as providing a basis for most neurotic disorders. But whatever the vagaries of habit, the fact remains that 73 per cent of the "accessory conditions" of principal diseases, ninety per cent of which are psychiatric, are also psychiatric. This fact illustrates the difficulties of diagnosis in psychiatry about which some remarks were made in Chapter One.

3. Age by Diagnosis.

In table 43 are included those diagnostic groups wherein the number exceeds a hundred in either sex. They comprise 8,295 patients, or 97 per cent of the total of 8,725 patients.

In table 43, the ages have been arranged in ascending order in respect of males, and the average ages of males and females are placed in adjacent columns in order to facilitate comparison. The average age for all groups is 37.2 years for males and 39.2 years for females. A transverse line, differently placed for men and women, separates those whose ages are below and above the average.

The following points are noteworthy:

(1) Much the biggest jump in age is between the last two categories—other psychoses and senile psychoses. The difference for males is 9½ years and for females 11 years. The Joint Hospital contains a unit for senile psychoses which has biassed the age-distribution.

(2) The youngest group in both sexes is that comprised by sexual deviations, though the number of women is small. The average age is just over thirty. It is in this early stage of life, before the person has adjusted himself to his abnormality, that these deviations are felt most keenly and treatment is sought. In later life the abnormality is accepted and a social adjustment of some sort is usually made. Many outpatients in this group (30.5 per cent) lapse in their attendance (table 60: page 81).

(3) Patients diagnosed as pathological or immature personalities have an average age in the early thirties; those diagnosed as anxiety, obsessive-compulsive neurosis and "other psychoneuroses" are slightly older, the averages being in the early and middle thirties; those diagnosed as neurotic depressives (a substantial fraction) are on average in the late thirties. Patients treated for alcoholic and drug addictions average in the early forties, manic-depressives (again a substantial fraction) in the late forties, and sufferers from "other psychoses" in the middle fifties.

(4) Except in two diagnostic groups, there is fairly close agreement between the average ages of the two sexes. The two exceptions are schizophrenia, where females average four years older than males (34.8 against 30.8), and hysteria where men average five years older than women (35.7 against 30.7). The number of men (159) is here less than half that of the women. Table 44 shows a breakdown by decennial age-groups for these two conditions:

Age Group	Schizophrenia				Hysteria			
	Males (451)		Females (424)		Males (159)		Females (344)	
	Nos.	%	Nos.	%	Nos.	%	Nos.	%
16–24	125	27.7	86	20.3	27	17.0	80	23.2
25–34	198	44.0	143	33.7	59	37.1	98	28.5
35–44	88	19.5	109	25.7	33	20.7	99	28.8
45–54	30	6.6	67	15.8	30	18.9	44	12.8
55–64	10	2.2	12	2.8	9	5.7	18	5.2
65+	—	—	7	1.7	1	0.6	5	1.5
Avge. Age	30.8		34.8		35.7		30.7	

Table 44. *Age by Diagnosis.*

875 Schizophrenic Patients (Discharges) and 503 Hysterical Patients (Discharges) in six Age-Groups: Sexes Compared.

It will be seen from table 44 that, among schizophrenics, young males exceed young females: of males, 71.7 per cent, and of females 54 per cent were under 35. Among hysterics, on the other hand, the distribution is more complicated, but the total of males (159) is small. Young females under 25 and those aged 35-44 are proportionately more numerous than males. The higher average age of males is mainly the result of the proportional excess of males in the age-groups 25-34 and 45-54. These differences may possibly be related to the ages at which claims for compensation for industrial accidents are made.

4. Marital Status by Diagnosis.

The proportion of single to married patients differs according to diagnostic group. One would expect that the groups containing numerous single patients would be young groups. This in some degree occurs. But that the proportion of the unmarried is otherwise influenced is made clear in table 45 which compares age with the percentage of single patients in ten diagnostic groups wherein the numbers are sufficiently large to be meaningful.

Diagnostic Group	Males (3,262)			Females (3,666)		
	No.	Average Age (years)	% Single	No.	Average Age (years)	% Single
1. Schizophrenia ...	451	30.8	75.0	424	34.8	58.2
2. Pathological and immature personalities	548	31.2	51.5	257	31.4	53.7
3. Obsessive - compulsive neurosis ...	129	33.2	52.7	119	34.7	37.0
4. Anxiety	655	33.7	32.7	578	34.3	26.0
5. Other psychoneuroses ...	294	35.7	33.0	291	35.5	32.6
6. Hysteria	159	35.7	32.1	344	30.7	37.5
7. Neurotic depression	463	39.0	31.7	850	37.6	26.9
8. Alcoholism & drug addiction ...	119	43.5	19.3	37	44.6	21.6
9. Manic - depressive reaction	375	47.2	22.9	640	46.1	27.2
10. Senile Psychoses ...	69	64.5	5.8	126	64.8	12.7

Table 45. *Marital Status.*

Proportion of Single (never married) Patients by Diagnosis and Average Age: 6,928 Patients (Discharges) in Ten Diagnostic Groups.

(1) Table 45 is arranged in an ascending order of the age of males which is not followed by that of females. Between the average ages of males falling into the first six groups, schizophrenics being the first and hysterics the sixth, there is a difference of less than five years. The same can be said for the first six groups of females. Between the average ages of the youngest female group of the six (hysterics: average age 30.7) and the oldest of the six (those diagnosed as having "other psychoneuroses"; average age 35.5) there is also less than five years. Yet there exist between these six groups differences in the proportions of the single which are much more pronounced than differences in age.

(2) Among schizophrenics are found the largest proportion of single patients. Three quarters of the 451 male schizophrenics are single; and nearly six tenths of the 424 female, though these rank fifth in average age. More than half of all males and females diagnosed as having pathological and immature personalities are single, and so are male obsessive-compulsives. Thirty seven per cent of female obsessive compulsives and 37.5 per cent of female hysterics are single, though there is a difference in average age of four years between the two groups.

(3) The proportions of single are closely similar for males in groups four to seven, namely those suffering from anxiety, other psychoneuroses, hysteria and neurotic depression; but the range of

average ages is over five years. Among females in these four groups (four to seven), the differences in both average age and nuptiality are more pronounced. The group whose average age is lowest, namely hysterics with an average age of 30.7, has the largest proportion of single, namely 37.5 closely resembling the figure for obsessive-compulsives. Relatively few women with anxiety and neurotic depression are single (26.0 and 26.9 per cent).

(4) Among men and women in the last three groups, whose average ages are above 43, the proportions of single are low. Here the association between relatively high nuptiality and relatively advanced age is closer; but the fact that fewer alcoholics and drug addicts of both sexes than older manic-depressives remain single may suggest that other factors than age are involved. But the numbers of the former are small and the differences in the percentages are not significant.

(5) Why do these diagnostic groups differ in their marrying habits? The figures do not help us to answer this question though many psychiatrists will find approximate answers in their clinical experience. It is readily understandable why few schizophrenics get married. The high proportion of unmarried men and women who are diagnosed as having pathological or immature personalities is also understandable. These patients not infrequently have intractable inhibitions about sex by reason of which they may be assigned to these diagnostic groups. The same may be said about the excessive scrupulosity and perfectionist aspirations of many obsessional neurotics. Each psychiatrist can find within the orbit of his clinical experience seemingly plausible reasons why nuptiality varies in different psychopathological and diagnostic groups.

5. Number of Brothers and Sisters (Size of Sibship).

It was remarked on page 22 that, in the course of the half century which elapsed between 1880 and 1930, during which most of the Joint Hospital's adult patients were born, the average size of the British family became steadily smaller. There is no doubt that the most important factor influencing the size of the sibships to which the patients belong is the date of their parents' marriage. For several obvious reasons this information is very difficult to obtain as a routine matter. There is the further difficulty, mentioned on page 23 (table 12a) that, as pointed out by Greenwood and Yule, the average size of recorded sibships of hospital patients overstates their real size.

Table 46 shows twelve diagnostic groups of which all except one (No. 11) comprises over 100 patients (males and females being taken together). The first ten groups are arranged in an ascending order of the ages of the male patients. As expected the sizes of the sibships tend to increase with the average ages of the persons comprised in each diagnostic group.

Diagnostic Group	Males (3,387)			Females (3,730)		
	No.	Avge. Age	Avge family Size	No.	Avge. Age	Avge. family size
1. Schizophrenia	451	30.8	4.0	424	34.8	4.3
2. Pathological and immature personalities	548	31.2	4.3	257	31.4	4.3
3. Obsessive - compulsive neurosis	129	33.2	4.3	119	34.7	3.9
4. Anxiety	655	33.7	4.7	578	34.3	4.9
5. Other psychoneuroses ...	294	35.7	4.5	291	35.5	4.3
6. Hysteria	159	35.7	4.6	344	30.7	4.8
7. Neurotic depression ...	463	39.0	5.0	850	37.6	4.8
8. Alcoholism and drug addiction	119	43.5	3.9	37	44.6	4.6
9. Manic-depressive reaction	375	47.2	5.1	640	46.1	5.3
10. Senile psychoses	69	64.5	5.6	126	64.8	6.8
11. Non-sexual delinquency or crime	57	32.5	4.9	19	31.3	5.1
12. Mental deficiency ...	68	27.1	4.6	45	32.4	5.4

Table 46. *Size of Patients' Sibships (including the patient) by Diagnosis and Average Age.*

7,117 Discharges in Twelve Diagnostic Groups.

The exceptions, among which the last two groups are noticeable (they combine a relatively low average age with a relatively large size of sibship), are mostly based on small figures. Though certain features of the table are perhaps suggestive, no inferences can be drawn.

6. Fertility: Number of Children Born Alive.

It was mentioned in Chapter Two, pages 24-25 that, with the exception of the age-group 25-34 and probably also that of 16-24, the fertility of the Joint Hospital's patients was probably below the national average. The average number of children born alive was for males 1.71, for females 1.63 and for both sexes together, 1.69. But the families of a large fraction of our patients are incomplete; those aged 34 and under amount to 47 per cent (page 16).

It was also mentioned above that, except for the year 1951, the last of the triennium, the duration of marriage had not been recorded, and though age has been tabulated against diagnostic group for a large sample of 8,295 discharges (table 43), it has not been separately tabulated for the smaller group of married patients.

Table 47 is therefore the best that our figures can provide.

In table 47 nine diagnostic groups from the nineteen-point list have been omitted because they contain too few married patients. In all ten of the above groups, the number of males and

females combined exceeds a hundred. The groups are arranged in an ascending order of the average age of the males as shown in table 45, schizophrenics being the youngest and senile psychotics the oldest.

Diagnostic Group	Males		Females	
	No.	Avge. No. of children	No.	Avge. No. of children
1. Schizophrenia	115	1.5	177	1.3
2. Pathological and immature personalities	266	1.5	119	1.9
3. Obsessive-compulsive neurosis...	61	1.6	75	1.3
4. Anxiety	441	1.5	428	1.5
5. Other psychoneuroses	197	1.5	196	1.4
6. Hysteria	108	1.9	215	1.3
7. Neurotic Depression	316	1.8	621	1.7
8. Alcoholism and drug Addiction	96	1.6	29	1.4
9. Manic-depressive reaction ...	289	1.9	466	1.9
10. Senile Psychoses	65	3.2	110	3.0
Average all groups	1,954	1.7	2,436	1.7

Table 47. *Fertility (Children Born Alive) by Diagnosis.*
4,390 Married Patients Discharged: Ten Diagnostic Groups.

It will be seen that the smallest number of children (1.3 children born alive) occur to females in the following groups; schizophrenia, obsessive-compulsive neurosis and hysteria. The largest number occur, as one would expect, to senile psychotics of both sexes (average of 3.0 for females and 3.2 for males). A relatively high figure of 1.9 children is also recorded of the following: manic-depressives of both sexes, male hysterics and females with pathological and immature personalities. But in the absence of information about the duration of, and age at, marriage, no inferences can be drawn.

The most conspicuous differences in fertility between the sexes were in respect of pathological and immature personalities (females more fertile than male) and of hysteria (males more fertile than females), as shown in table 48:

Diagnostic Group	Males		Females	
	No.	Avge. No. of children	No.	Avge. No. of children
Pathological and Immature personalities	266	1.5	119	1.9
Hysteria	108	1.9	215	1.3

Table 48. *Fertility (Children born alive) by Diagnosis.*
Averages for Patients with Pathological and Immature Personalities and with Hysteria by Sex.

These differences may be largely attributable to differences in age at, and duration of, marriage of which particulars are not here available. A better picture will emerge in later triennial reports.

7. Previous Admissions to Joint Hospital at Any Time.

The term admission is defined on page 33 but it may be mentioned here that every admission into a ward is counted as such irrespective of the length of time since an earlier admission; and, subject to the exceptions earlier specified, an admission to the outpatient department is counted as such when a period of three months or more has elapsed since the patient last attended the hospital. Table 49 covers previous admissions both to the wards and the outpatient department. Thus the number of *admissions* of outpatients are to be distinguished from the number of *attendances* in the course of a single admission. The latter are discussed by diagnosis below (pages 69-71).

Diagnostic Group	Males Admission Ratio	Females Admission Ratio	Totals		
			Admission Ratio	No. of Patients	No. of Admissions
(a)	(b)	(c)	(d)	(e)	(f)
Schizophrenia	174	181	177	875	1,553
Manic-depressive reaction	202	203	203	1,015	2,059
Senile psychoses	151	134	140	195	273
Other psychoses	175	168	170	345	586
Anxiety	143	140	142	1,233	1,750
Hysteria	137	155	150	503	753
Obsessive-compulsive reaction	174	203	188	248	465
Neurotic depressive reaction	155	161	159	1,313	2,083
Other psychoneuroses ...	140	150	145	585	850
Pathological and immature personalities	145	157	148	805	1,196
Sexual deviations ...	123	[220]	128	187	239
Alcoholism and drug addictions	155	[154]	154	156	240
Miscellaneous	147	153	150	835	1,252
Totals	156	165	160	8,295	13,299

Table 49. Number of Previous Admissions by Diagnosis.
Thirteen Diagnostic Groups: Admission Ratios: 8,295 Discharges (See text: Admission ratios based on less than fifty cases are in brackets).

It will be seen from table 49 that thirteen of the nineteen diagnostic groups are considered. The other six were omitted because the numbers were too small. Of the total of 8,725 patients, 8,295 (97.4 per cent) are here considered (column e).

These were admitted to the hospital 13,299 times (column f). The admission ratio is the number of admissions per hundred patients, counting the present admission as one. Thus if no patient in a group had before been admitted, the ratio would be 100. If every patient had been admitted exactly once before, the ratio would be 200. The numbers of patients in each diagnostic group in respect of whom the number of previous admissions was known are shown in column e; and the total number of their admissions, counting the current admission, is shown in column f. The figures in column d are produced by dividing the figures in column f by those in column e, and multiplying the quotient by a hundred.

It will be seen that the combined ratio for both sexes is 160 and that the ratio is slightly higher for women than men—165 against 156 (columns b and c).

The highest ratio (203) is provided by manic-depressives (column d), the figures for the two sexes being closely similar.

Next highest are obsessive-compulsives (ratio 188), among whom females have a higher figure (203) than males (174). Schizophrenia (ratio 177) also ranks high, the figure for females (181) again being higher than for males (174).

The high admission ratio of 220 for female sexual deviants means nothing, for of the total of 187 male and female patients (column e), only ten were females. Indeed, the lowest ratio for both sexes combined (column d) is 128 for sexual deviations; and it is understandable that the majority of these mostly intractable cases should not regard frequent visits to hospital as of advantage, though a minority, who have established good relations with a doctor, may find themselves helped by supportive treatment.

Senile psychotics have the next lowest ratio of 140, males slightly exceeding females in the number of previous admissions. This is in accordance with expectation. The low ratio of 142 for patients with anxiety, closely similar for the two sexes, is somewhat surprising.

8. Duration of Stay in Hospital: Inpatients.

The matter was earlier mentioned on page 39. In table 50 are given the diagnoses for each sex in descending order of the duration of stay. Diagnostic groups comprising small numbers of patients are omitted. The numbers on which the calculation is based are given after the diagnosis.

The transverse lines separate groups above from those below the average for all inpatients.

It is not clear why, in table 50, schizophrenics easily top the list

for males, with an average duration of stay 4.6 months, but rank low (below the average) for females with corresponding figure of 3.7 months; nor why females diagnosed as having pathological and immature personalities (average duration 4 months) should stay in hospital over a month longer than males (average duration 2.9 months). It will be seen from table 58 that the proportion discharging themselves against advice is little higher for males (21.2 per cent) than for females (18.2 per cent).

Males (1,180) Twelve Diagnostic Groups	Avge. duration of Stay (mth.)	Females (1,546) Ten Diagnostic Groups	Avge. duration of Stay (mth.)
Schizophrenia (232) ...	4.6	Obsessive-compulsive reaction (49)	4.7
Other Psychoses (46) ...	4.0	Other psychoses (149) ...	4.5
Obsessive-compulsive reaction (50)	3.9	Pathological and immature personalities (77)	4.0
Manic-depressive reaction (218)	3.4	Manic-depressive reaction (352)	4.0
Anxiety (120)	3.4		
Hysteria (41)	3.4	Senile Psychosis (45) ...	3.9
Organic disorders of the C.N.S. (43)	3.4	Schizophrenia (257)... ...	3.7
Senile psychoses (31) ...	3.1	Anxiety (125)	3.4
Pathological and immature personalities (113) ...	2.9	Hysteria (133)	3.2
Neurotic depressive reaction (166)	2.8	Neurotic depressive reaction (341)	3.1
Other psychoneuroses (61)...	2.8		
Alcoholic and Drug addictions (59)	2.0	Alcoholic and drug addictions (18)	1.8
Average duration of stay for 1,397 males — 3.6 months.		Average duration of stay for 1,848 females—4.0 months.	

Table 50. *Duration of Stay in Months by Diagnostic Groups.*
2,726 Inpatient Discharges: Twelve Groups of Males, Ten of Females.

A unit for the antabuse treatment of alcoholism exists at the Maudsley Hospital. Because the average duration of stay (which is short) for this group may be of interest, it is included in the table, though the numbers are small.

9. Number of Times Seen (Attendances): Outpatients.

The number of times that outpatients were seen was discussed on pages 39-40, and what follows should be understood in the light of what was there said. In order to avoid confusion, it should here

be repeated that the number of times a patient is seen (the number of his attendances) relates to the number of his interviews with doctors on the Joint Hospital's staff in the course of single admission as above defined (page 33).

In Table 51 the average number of times seen is given only for patients in those diagnostic groups wherein the attendances are most numerous for each sex. Of the total of 7,713 outpatient discharges 3,601 are covered in the table. The numbers of patients on which the calculation is based are given after the diagnoses.

1,653 Males Six Diagnostic Groups	Avge. No. times seen	1,948 Females Six Diagnostic Groups	Avge. No. times seen
Obsessive-compulsive reaction (111)	7.5	Obsessive-compulsive reaction (115)	5.2
Sexual deviations (174) ...	5.7	Anxiety (549)	3.9
Neurotic depressive reaction (420)	4.5	Manic-depressive reaction (508)	3.8
Other psychoneuroses (266)	4.0	Pathological and immature personalities (225) ...	3.7
Delinquency or crime (51) ...	3.9	Hysteria (287)	3.5
Anxiety (631)	3.8	Other psychoneuroses (264)	3.3
Average for all diagnostic groups: (3,794 patients)	3.3	Average for all diagnostic groups: (3,919 patients)	3.0

Table 51. *Number of Times Seen.*

Six Diagnostic Groups with most numerous Attendances for each Sex: 3,601 Outpatients.

The fact that the average number of times seen in the outpatient department is slightly higher for men than women may reflect the fact that admission to hospital often involves less dislocation when the housewife is involved than the main breadwinner. It will be seen from Table 54 that relatively more women (24.5 per cent) than men (20.6 per cent) are admitted from the outpatient department to the wards. Men patients may prefer, when possible, to be treated as outpatients. Anxieties among inpatients about the social and economic effects, and the bearings on their future, of a stay of three months in hospital are commoner among men than women.

The fact that obsessive-compulsive neurotics easily head both lists is not surprising in view of the intractable nature of this neurosis. But it is not immediately obvious why patients diagnosed as having neurotic depressive reactions should come high on the list for males (4.5 times seen) and low on that for females (average number of times seen 3.1: not shown on the above list); and why the opposite holds for the manic-depressive reaction, which appears third on the list for females (3.8 times seen) and low on that for

males (average number of times seen 2.4: not shown in the Table). Part of the answer may be that more women than men suffer from attacks of depression occurring in rhythms or short cycles which respond well to psychotherapy. Such may be more appropriately assigned to the category of manic-depressive reaction than to the other. The difficulties to which these diagnostic categories give rise were discussed on page 7.

10. Special Treatment: Inpatients.

The matter was earlier mentioned on page 42. The nature of "special treatment" was there discussed and it was mentioned that just over half the total of inpatients (51.6 per cent) received one or more such treatments. More women (57.1 per cent) were so treated than men (44.3 per cent). In particular, more women than men were treated by E.C.T. (35.3 against 19.4 per cent) ,and more by modified insulin (7.5 per cent against 3.8 per cent). It should be noted that, for reasons mentioned earlier, psychotherapy has not been included here under the heading of Special Treatment.

The breakdown by diagnosis shows expected features. The diagnostic groups of meaningful size wherein most special treatments were used are schizophrenia, manic-depressive reactions, alcoholism and drug addiction, and "other psychoses"; the groups wherein fewest were used were anxiety, hysteria, "other psychoneuroses", pathological and immature personalities, and senile psychoses.

Of 489 *schizophrenics*, 64 per cent received one or more special treatments. More women were treated than men—70 against 56 per cent. Of both sexes combined, 30 per cent were treated by E.C.T. and 37 per cent by deep insulin.

Of 570 *manic-depressives*, 70 per cent received special treatments —63 per cent by E.C.T.

Of 77 *alcoholics and drug addicts*, 62 per cent received special treatments, many of them by antabuse.

Of 195 patients with "*other psychoses*" 81 per cent received special treatment, 72 per cent by E.C.T.

Figures for the diagnostic groups wherein special treatments were least applied are as follows:

Of 245 patients with *anxiety*, 31 per cent received one or more such treatments; of 174 *hysterics*, 29 per cent; and of 137 diagnosed as having "*other psychoneuroses*", 32 per cent.

Of 190 patients having *pathological or immature personalities*, 29 per cent received special treatment. More of these were women than men—43 against 19 per cent.

Of 76 patients with *senile psychoses*, twenty three (30 per cent) received one or more special treatments. Fourteen were given E.C.T; fourteen special drug treatments and one modified insulin.

11. Outcome by Diagnosis: Inpatients.

Diagnostic Group	No. of Patients	Recovered or much Improved		Improved or Slightly Improved		No Change, Worse, died or suicide	
		No.	%	No.	%	No.	%
Manic depressive reaction	570	423	74.2	101	17.7	46	8.1
Neurotic depressive reaction	507	311	61.3	151	29.8	45	8.9
Schizophrenia ...	489	182	37.2	132	27.0	175	35.8
Anxiety	245	113	46.1	89	36.3	43	17.6
Other psychoses ...	195	138	70.8	40	20.5	17	8.7
Pathological and immature personalities	190	34	17.9	93	48.9	63	33.2
Hysteria	174	71	40.8	55	31.6	48	27.6
Other psychoneuroses	137	44	32.1	61	44.5	32	23.4
Obsessive - compulsive reaction ...	99	39	39.4	39	39.4	21	21.2
Totals ...	2,606	1,355	52.0	761	29.2	490	18.8

Table 52. Outcome by Diagnosis.

2,606 Inpatient Discharges: Nine Diagnostic Groups.

The outcome tabulated in table 52 is that recorded when an inpatient is discharged from hospital. The figures, which take no account of later relapses, are almost certainly more favourable than those which could result from a later follow-up of the same patients.

The nine diagnostic groups shown in table 52 are arranged in a descending order of the numbers comprised in the groups. Ten categories shown in the nineteen point list (table 32), each of which comprises less than a hundred patients, are omitted, leaving 2,606 (81 per cent) of the total of 3,245 inpatients. The sexes are not separated, the numbers being too small. The outcome of treatment was discussed in Chapter Three, pages 43 and 44 (table 27). The sexes were there separated, and it was shown that the results were rather more favourable for females than for males. The difference was mainly due to an excess of women over men in the two well-represented "depressive-reaction" groups which have a favourable prognosis.

It will be seen from table 52 that the three groups which responded best to hospital treatment are the two depressive groups and that of "other psychoses" which contains puerperal cases. In these three groups, over sixty per cent were discharged as recovered or much improved and under nine per cent as no better.

The group of anxieties makes a bad fourth; forty-six per cent left recovered or much improved and eighteen per cent were no better.

The group that benefited by far the least is that comprising patho-

logical and immature personalities. Of these patients 18 per cent left recovered or much improved and a third (33 per cent) left no better. Under half (48.9 per cent) were recorded as having improved or slightly improved. This finding is in accordance with expectation, for the group is refractory, the disability being regarded as an expression of the structure of the personality.

The groups, hitherto not mentioned, which contain the largest proportion of patients who were no better when discharged are schizophrenia (35.8 per cent left no better), and hysteria (27.6 per cent no better). It should however be noted (table 58) that it is in these two groups and in that mentioned in the foregoing paragraph (pathological and immature personalities) that the proportion of patients discharging themselves against advice was largest. The percentages of such discharges against advice are—schizophrenia 21 per cent, pathological and immature personalities 20 per cent, and hysterics 18.4 per cent (table 58). It is easy to understand that such cases did not benefit from hospital treatment.

12. Disposal.

A. Inpatients sent for Residential Treatment Elsewhere.

The disposal of inpatients was discussed in Chapter Three (pages 44 and 45; table 28). Multiple disposals (4,228 disposals of 3,245 patients) were tabulated in five main groups as follows:

Referred back to private doctor	32.0 per cent
Referred for further treatment or supervision at Joint Hospital	62.4 per cent
Referred for residential treatment outside	10.9 per cent
Other disposals	13.1 per cent
Discharged against advice	13.8 per cent

The breakdown by diagnosis shows no noteworthy features except in respect of those patients sent for residential treatment elsewhere and who discharged themselves against advice. The latter are discussed under the heading *Mode of Leaving* on page 80 below.

In table 28 (page 44) it was shown that 10.9 per cent of patients were sent for residential treatment elsewhere. Five such disposals were shown in table 28 of which those numbered 5-7 were numerically the most important, namely referrals to observation wards, to mental hospitals, and to non-mental hospitals. To these three destinations were sent 9.6 per cent of males, 8.3 per cent of females and 8.9 per cent of both sexes combined.

The diagnostic groups which contained the largest proportions of patients sent to these three destinations were those comprising schizophrenics and miscellaneous cases, among which (table 38, page 57) epileptics and sufferers from organic illnesses were well represented.

The percentages were as follows:

Diagnostic Group	Males	Females	Total
Schizophrenics	22.0	20.5	21.4
Miscellaneous	16.8	19.1	17.9

Table 53. *Disposal.*

Percentages of 489 Schizophrenic Patients and of 318 Miscellaneous Cases (Inpatients) sent to Observation Wards, Mental, and other Hospitals.

The high disposal rates to other hospitals and institutions for patients in these two diagnostic groups are in accordance with expectation. Many schizophrenics fail to benefit from treatment, and, as shown in Table 38, the Miscellaneous Group contains many epileptics and sufferers from organic diseases who need prolonged hospital or institutional treatment.

B. Outpatients: Admissions to Hospital.

This matter was discussed in Chapter Three (pages 45 and 46).

Two features of the breakdown by diagnosis will here be considered, namely (a) the proportions admitted to the wards of the Joint Hospital and (b) those recommended for admission to Observation wards and Mental Hospitals.

(a) *Outpatients Admitted to Joint Hospital as Inpatients:*

It will be seen from table 54 that the admission rate to the wards of the Joint Hospital is 22.6 per cent for both sexes combined. Thus between a quarter and a fifth of patients seen in the outpatient department were admitted to the wards. The rate is higher for females (24.5 per cent) than for males (20.6 per cent).

In five of the nineteen diagnostic groups the total number of patients (totals column (a)) is less than a hundred, namely in those relating to paranoid states, organic disorders of the central nervous system, psychosis resulting from epilepsy, non-sexual delinquency and primary childhood disorders. In what follows the remaining fourteen diagnostic groups, in which the number exceed a hundred, will be considered. It will be seen that in these the admission rate varies within the wide limits of 46.8 per cent for the miscellaneous group and 5 per cent for sexual deviations.

The high rate for miscellaneous cases, involving the admission of nearly half the female outpatients so diagnosed (49.7 per cent), is understandable in the light of the high proportion of organic cases here comprised (table 38). The next highest admission rate is that for alcoholics and drug addicts (36.6 per cent). The Maudsley hospital contains a unit for the special drug treatment of alcoholics, and many of these intractable cases are referred from the outside for inpatient treatment. The high admission rate is therefore to be expected. No such special treatment exists for the equally in-

Diagnostic Group	Males			Females			Totals		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
Schizophrenic disorders	327	70	21.4	288	78	27.1	615	148	24.1
Manic - depressive reaction... ...	291	103	35.4	508	154	30.3	799	257	32.1
Paranoia and paranoid states ...	38	10	26.3	38	9	23.7	76	19	25.0
Senile psychoses with cerebral arteriosclerosis ...	51	14	27.5	93	11	11.8	144	25	17.3
Organic disorders of the C.N.S. ...	23	6	26.1	20	3	15.0	43	9	20.9
Psychosis resulting from epilepsy ...	6	2	33.3	6	3	50.0	12	5	41.6
Other psychoses ...	65	19	29.3	224	68	30.3	289	87	30.1
Anxiety	631	76	12.0	549	75	13.7	1,180	151	12.8
Hysteria	134	12	9.0	287	50	17.4	421	62	14.7
Obs. Comp. reaction	111	25	22.5	115	34	29.6	226	59	26.1
Neur. depressive reaction... ...	420	100	23.8	764	192	25.1	1,184	292	24.6
Other psychoneuroses ...	266	22	8.3	264	31	11.7	530	53	10.0
Pathological and Immature personality... ...	484	30	6.2	225	25	11.1	709	55	7.8
Sexual deviations...	174	9	5.2	6	—	—	180	9	5.0
Non-sexual delinquency	51	1	2.0	18	—	—	69	1	1.5
Alcoholic & drug addictions ...	99	36	36.4	32	12	37.5	131	48	36.6
Primary childhood disorders ...	10	2	20.0	11	—	—	21	2	9.5
Mental deficiency	65	—	—	40	—	—	105	—	—
Misc. Diagnosis outside Code Nos. 300–325	548	244	44.5	431	214	49.7	979	458	46.8
Totals	3,794	781	20.6	3,919	959	24.5	7,713	1,740	22.6

(a) = Patients seen in Outpatient Department.

(b) = Patients warded in Joint Hospital from the Outpatient Department.

(c) = Percentage warded of outpatients.

Table 54. *Admission to Wards of Joint Hospital from* 7,713 *Outpatient Discharges.*

Nineteen Diagnostic Groups.

tractable cases of sexual deviation (nearly all males) which are best treated as outpatients (admission rate 5 per cent).

Also high above the average of 22.6 per cent, are the admission rates for manic-depressive patients (32.1 per cent) and for the group "other psychoses" (30.1 per cent) wherein women, many of them puerperal cases and therefore highly suitable for admission, much outnumber men. It is perhaps surprising that the admission rates for obsessive-compulsive patients (26.1 per cent) and for neurotic depressive patients (24.6 per cent) are higher than that for schizophrenics (24.1 per cent); but many of the latter, when seen as outpatients, are deemed unsuitable for admission to the Joint Hospital and are recommended for admission elsewhere (see table 57 below).

At the other end of the scale of admission rates—that is to say well below the average rate of 22.6 per cent—are the rates for hysterical patients (14.7 per cent), for patients with anxiety (12.8 per cent) and for those with pathological and immature personalities (7.8 per cent). These groups are best dealt with as outpatients. The lowest rate is that of sexual deviations above mentioned (5.0 per cent).

A simple conspectus (table 55) can be obtained from the four point classification presented in tables 35 and 37.

Diagnostic Assortment and Rubrics	Males			Females			Totals		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
Psychoses (300-309)	801	224	28.0	1,177	326	27.7	1,978	550	27.8
Psychoneuroses (310-318) ...	1,562	235	15.0	1,979	382	19.3	3,541	617	17.4
Disorders of Character, etc. (320-326) ...	883	78	8.8	332	37	11.1	1,215	115	9.6
Miscellaneous ...	548	244	44.5	431	214	49.7	979	458	46.8
Totals	3,794	781	20.6	3,919	959	24.5	7,713	1,742	22.6

(a) = Total numbers.
(b) = Numbers admitted to wards of Joint Hospital.
(c) = Percentage admitted.

Table 55. *Admissions to Wards of Joint Hospital from* 7,713 *Outpatient Discharges by Four Major Diagnostic Assortments.*

It will be seen from table 55 that the admission rate for patients with psychoses (27.8 per cent) is conspicuously higher than for those with psychoneuroses (17.4 per cent); and that the rate for patients with disorders of character personality and intelligence is easily the lowest. The admission rate for males and females is the same for patients with psychoses; but in the other three assortments the rate is higher for females, thus accounting for the higher overall rate for females (24.5 per cent) compared to males (20.6 per cent).

(b) *Referrals of Outpatients to Observation wards and Mental Hospitals*:

Of the other methods of disposal of outpatients wherein a breakdown by diagnosis is of interest are admissions to observation wards and mental hospitals. The percentages were shown in table 29. Referrals of outpatients to these two destinations amounted to 8.7 per cent of all referrals of outpatients, 5.7 per cent being recommended for admission to mental hospitals and 3.0 per cent to observations wards.

It should here be mentioned that these two disposals are appropriate for different types of patients. Those referred to mental hospitals go voluntarily; those referred to the Duly Authorised Officer for admission to an observation ward may or may not go voluntarily. Most are acutely ill; they may be violent or dangerous to themselves or others. Admission to an observation ward may be a preliminary to certification.

The percentages of patients shown in table 29 as having been sent to these two destinations are reproduced in table 56 together with the numbers on which they are based.

Admissions recommended to:	Males (3,794)		Females (3,919)		Totals (7,713)	
	No.	%	No.	%	No.	%
Mental Hospital	210	5.5	232	5.9	442	5.7
Observation Ward	87	2.3	146	3.7	233	3.0
Totals	297	7.8	378	9.6	675	8.7

Table 56. *Disposal of* 7,713 *Outpatient Discharges.*

Admissions recommended to Mental Hospitals and Observation Wards.

It will be seen from table 56 that appreciably fewer patients of both sexes were sent to observation wards than to mental hospitals —233 compared with 442.

The numbers of these referrals by diagnostic group were largest for schizophrenics and manic-depressive patients. This is in accordance with expectation. The figures are shown in Table 57.

It will be seen that the proportion of schizophrenics disposed of in these two ways was larger than that of manic-depressives, especially in respect of those sent to observation wards. Of schizophrenic outpatients, 10.1 per cent were sent to observation wards and another 15.8 per cent were sent to mental hospitals—a total of 25.9 per cent disposed of in these two ways. It was seen (table 54) that 24.1 per cent of schizophrenics were admitted as inpatients

to the Joint Hospital; it follows that exactly 50 per cent of schizophrenic outpatients were disposed of by either admitting them to the wards of the Joint Hospital, or recommending their admission to observation wards and mental hospitals.

Of 799 manic-depressive patients, 32.1 per cent were admitted to the wards of the Joint Hospital (table 54); a further 7.9 and 14.6 per cent were respectively recommended for admission to observation wards and mental hospitals (table 57). Hence 54.6 per cent were disposed of by admission to the wards of the Joint Hospital and by recommended admission to observation wards or mental hospitals.

	Males			Females			Total	
	No.	Obs.	M.H.	No.	Obs.	M.H.	Obs.	M.H.
Schizophrenia (615 patients)	327	9.4	18.2	288	10.8	13.2	10.1	15.8
Manic - depressive reaction (799 patients) ...	291	4.8	13.0	508	9.6	15.6	7.9	14.6

Obs. = Percentage referred to Observation wards.

M.H. = Percentage referred to Mental Hospitals as Voluntary Patients.

Table 57. *Disposal of* 615 *Schizophrenic and of* 799 *Manic-depressive Outpatient Discharges.*

Percentages referred to Observation Wards and Mental Hospitals.

It will further be seen from table 56, which deals with all outpatients, that rather more females than males were dealt with by recommended admission to observation wards and mental hospitals —9.6 against 7.8 per cent. Table 57, which deals with schizophrenics and manic-depressives, shows that, of schizophrenics, about the same proportion of males as females—9.4 against 10.8 per cent —were sent to observation wards. But of manic-depressives, twice as many females as males were so sent—9.6 compared with 4.8 per cent.

13. Mode of Leaving.

Inpatients Discharging themselves against Advice.

The overall figure for inpatients who discharged themselves against advice was shown in table 30 to be 13.8 per cent.

In Table 58 the figures are given for those diagnostic groups in which the total number exceeds fifty; the table which comprises eleven of the nineteen diagnostic groups relates to 3,001 patients (the remaining groups containing too few patients for inclusion in a breakdown by diagnosis).

It will be seen (totals column) that the self-discharge rate varies much by diagnostic group; it is two and a half times higher for schizophrenics than for "other psychoses" and "miscellaneous cases".

Diagnostic Group	Males (1,267)			Females (1,734)			Totals (3,001)		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
Schizophrenia ...	232	49	21.1	257	54	21.1	489	103	21.1
Manic depressive reaction ...	218	23	10.5	352	33	9.4	570	56	9.8
Other psychoses ...	46	4	8.7	149	12	8.1	195	16	8.2
Anxiety	120	15	12.5	125	14	11.2	245	29	11.8
Hysteria	41	1	2.4	133	31	23.3	174	32	18.4
Obsessive - compulsive reaction ...	50	8	16.0	49	5	10.2	99	13	13.1
Neurotic depressive reaction... ...	166	23	13.8	341	50	14.7	507	73	14.4
Other psychoneuroses ...	61	6	9.8	76	8	10.5	137	14	10.2
Pathological and immature personalities	113	24	21.2	77	14	18.2	190	38	20.0
Alcoholism & Drug addiction ...	59	13	22.0	18	1	5.6	77	14	18.2
Miscellaneous ...	161	8	5.0	157	18	11.5	318	26	8.2

(a) = Number of inpatients.

(b) = Number discharging themselves against advice.

(c) = Percentage discharging themselves against advice.

Table 58. *Mode of Leaving.*

Proportions Discharging Themselves against Advice: 3,001 Inpatient Discharges.

The highest rates are found among schizophrenics (21.1 per cent) and pathological and immature personalities (20.0 per cent). Of patients in these two groups, a fifth discharge themselves against advice. High self-discharge rates also occur among hysterics (18.4 per cent, the rate being conspicuously higher for women than for men among whom compensation cases are well represented); also among alcoholics and drug addicts (18.2 per cent), the rate here being much higher for men than women of whom there were but eighteen.

Low rates occur among "other psychoses" (where women, many of them puerperal cases, outnumber men) and miscellaneous cases (8.2 per cent in both groups). Low rates also occur among manic-depressives (9.8 per cent).

These differences in self-discharge rates are in general in accordance with expectation.

Outpatients: Lapses by Diagnosis.

The mode of leaving was discussed in table 31 (page 47). It was there mentioned that, of every 100 outpatients, 80.5 were normally discharged, 19.3 lapsed and 0.2 died or committed suicide.

From the standpoint of a breakdown by diagnosis, the most interesting feature of table 31 is the proportion of outpatients who lapse—that is to say who fail to keep an appointment without notifying, or returning to, the hospital. These are comparable with inpatients who discharge themselves against advice, and can, in a measure, be regarded as failures of treatment.

Diagnostic Assortment	Males			Females			Totals		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
300-309 Psychoses	801	157	19.6	1,177	163	13.8	1,978	320	16.2
310-318 Psychoneuroses ...	1,562	348	22.3	1,979	425	21.5	3,541	773	21.8
320-326 Disorders of character, etc.	883	204	23.1	332	77	23.2	1,215	281	23.1
Miscellaneous ...	548	69	12.6	431	45	10.4	979	114	11.7
Totals	3,794	778	20.5	3,919	710	18.1	7,713	1,488	19.3

(a) = Total Patients.
(b) = Number lapsed.
(c) = Percentage lapsed.

Table 59. Mode of Leaving.
Lapses in Outpatient Attendances grouped in Four Major Diagnostic Assortments: 7,713 Outpatient Discharges.

Table 59 shows the four main assortments adopted by the International classification in its partitioning of rubrics 300—326.

It will be seen from the right hand column that the proportions of outpatients who lapse differ in the three assortments. Apart from the Miscellaneous group, the best performance is given by patients in the psychotic group of whom 16 per cent lapse. But the difference between males and females is here more pronounced than in the other two groups. Of psychotic males, 19.6 per cent and of females 13.8 per cent lapse.

Over five per cent more of psychoneurotic patients lapse than of psychotic patients (21.8 against 16.2 per cent). The reason is not clear. The explanation may be that psychoneurotic patients as a group are asked to make more return visits and are disposed of less quickly and drastically, thus having wider scope for lapsing.

The lapse rate of patients with disorders of character is the highest. This is in general accordance with expectation. The proportions are almost exactly the same for the two sexes, which is perhaps surprising, in view of the casual ways and feckless habits of many men in this category.

Diagnostic Group	Males			Females			Totals		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
Schizophrenia ...	327	71	21.7	288	50	17.3	615	121	19.7
Manic depressive reaction... ...	291	50	17.2	508	69	13.4	799	119	14.9
Paranoia and paranoid states ...	38	6	15.8	38	6	15.8	76	12	15.8
Senile psychoses ...	51	6	11.8	93	6	6.5	144	12	8.3
Organic disorders of the C.N.S. ...	23	5	21.7	20	3	15.0	43	8	18.6
Psychosis resulting from epilepsy ...	6	1	16.7	6	1	16.7	12	2	16.7
Other psychoses ...	65	18	27.7	224	28	12.5	289	46	15.9
Anxiety	631	150	23.8	549	132	24.0	1,180	282	23.9
Hysteria	134	30	22.4	287	45	15.7	421	75	17.8
Obsessive compulsive neurosis ...	111	26	23.4	115	22	19.1	226	48	21.2
Neurotic depressive reaction ...	420	83	19.7	764	178	23.3	1,184	261	21.9
Other psychoneuroses ...	266	59	22.2	264	48	18.2	530	107	20.2
Pathological and immature personalities	484	115	23.8	225	56	24.9	709	171	24.1
Sexual deviations	174	53	30.5	6	2	33.3	180	55	30.5
Non-sexual delinquency	51	7	13.7	18	4	22.2	69	11	15.9
Alcoholism & drug addictions ...	99	18	18.2	32	9	28.1	131	27	20.6
Primary childhood disorders ...	10	2	20.0	11	4	36.4	21	6	28.6
Mental deficiency	65	9	13.8	40	2	5.0	105	11	10.5
Miscellaneous ...	548	69	12.6	431	45	10.4	979	114	11.7
Total	3,794	778	20.5	3,919	710	18.1	7,713	1,488	19.3

(a) = Total Patients. (b) = Number lapsed. (c) = Percentage lapsed.

Table 60. *Mode of Leaving.*
Lapses in Outpatient Attendances: 7,713 Outpatient Discharges: Nineteen Diagnostic Groups.

Table 60 shows a more detailed breakdown. It will be seen that the diagnostic group with the highest "lapse rate" is that of Sexual Deviations which comprises 180 patients almost all of whom are males. Of these nearly a third (30.5 per cent) lapsed. The group of Pathological and Immature Personalities also ranks high: nearly a quarter (24.1 per cent) lapsed. Rather surprisingly this group is closely followed by that comprising Anxiety States, numbering nearly twelve hundred; of these, 23.9 per cent lapsed, there being little difference between the sexes. Of 421 hysterical patients, 17.8 per cent lapsed, their performance being rather surprisingly better than that of obsessive-compulsive neurotics, neurotic depressives and "other psychoneuroses", all numerically well represented, who cluster round the mean of 21.8 per cent for psychoneurotics in general as shown in table 59. Senile psychotics (144) and mental defectives (105), some of whom are brought to the hospital by relatives, do well, with lapse-rates of 8.3 and 10.5 respectively.

CHAPTER FIVE.

CHILDREN.

1. INTRODUCTION.

Basic Figures: Arrangement of Chapter: History of Children's Department.

Basic figures are shown in table 1 at the beginning of Chapter One. It will be seen that the figures for children differ from those for adults in three main respects: the total figures are much smaller (1,211 compared with 7,787); boys easily outnumber girls (747 against 464), whereas among adults females outnumber males; and inpatients form a smaller fraction of total patients (22.0 per cent of children against 37 per cent of adults).

The arrangement of this chapter follows that of the preceding chapters; that is to say that, as in Chapter Two, the demographic, social and economic features will be first considered in sections 2 to 8. In these sections the figures in the contained tables (numbered 61 to 70) relate to individual children discharged during the triennium and not to discharges, a few of which were multiple for the same child.

The remaining sections of this chapter deal, as does Chapter Three, with the child's contacts with the hospital. The figures in the tables numbered 71—80 contained in these sections denote not individual patients but discharges, a few multiple for the same patient, during the triennium. Such multiple discharges, fewer for children than adults, are shown in table 61:

	Inpatients	Outpatients	Total
Boys (747) ...	17	16	33
Girls (464) ...	17	8	25

Table 61. *Multiple Discharges during the Triennium.*
1,221 Children.

Of boys, 4.4 per cent and of girls 5.4 per cent were discharged more than once during the triennium.

No worthwhile breakdown by diagnosis, such as was given for adults in Chapter Four, is possible because there does not yet exist a satisfactory diagnostic classification of the psychiatric ailments of children.

Children have been seen as outpatients since the early days of the Maudsley Hospital. The first clinic was held in what is now the lecture theatre of the Institute of Psychiatry by Dr. Rosalie Lucas in 1926, and was established in the charge of Dr. Mildred Creak in 1930. The present children's block was formally opened in July 1939. It contains a well-equipped and spacious outpatient department and an inpatient unit which now accommodates twenty-five children under the age of twelve.

Age Group	Boys						Girls					
	I.P.s		O.P.s		Combined		I.P.s		O.P.s		Combined	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0— 4	4	2.6	63	10.6	67	9.0	2	2.1	40	10.9	42	9.1
5— 9	58	37.9	237	39.9	295	39.5	19	19.6	134	36.5	153	33.0
10—15	91	59.5	294	49.5	385	51.5	76	78.3	193	52.6	269	57.9
Total	153	100.0	594	100.0	747	100.0	97	100.0	367	100.0	464	100.0

Table 62. *Age.*

1,211 Children: 747 Boys, 464 Girls: In- and Outpatients shown separately.

The children's unit is structurally a part of the Maudsley Hospital, being accessible from the adults' unit without going out of doors. The two units have different entrances and, though closely linked, are functionally separate, with different registries.

Wards for adolescent patients aged from twelve to seventeen were established at Bethlem Royal Hospital in 1949; they accommodate sixteen girls and seventeen boys

2. Distribution by Age and Sex.

This is shown in table 62.

It will be seen (table 62) that, of the total of 1,211 patients, over half (51.5 per cent of boys and 57.9 per cent of girls) were over ten and that less than a tenth (9 per cent) were under five. Inpatients were older than outpatients; two-thirds of the former against half of the latter were over ten. Girls were older than boys, the difference being most pronounced for inpatients of whom 78 per cent of girls against 59 per cent of boys were over ten. Admission as an inpatient involves separating the child from its parents. The more advanced age of inpatients compared with outpatients implies reluctance to separate very young children from their parents. Of the total of 1,211 children, 109 (9.0 per cent) were under five. Of these, six only (2.1 per cent of inpatients) were warded.

Admission to the Joint Hospital's children's ward has been sought from all over the country because of the urgency of the problems created by the behaviour difficulties of children. These problems are more numerous among boys than girls, and more numerous and pressing among older than young girls. They have influenced the ratio of admissions, both as inpatients and outpatients, of boys to girls and of older to younger boys and girls.

3. Marital Status of Parents.

Marital Status	Boys (747)		Girls (464)		Totals (1,211)	
	No.	%	No.	%	No.	%
1. Single	14	1.0	11	2.4	25	2.1
2. Married	620	83.0	386	83.2	1,006	83.1
3. Widowed	37	5.0	20	4.3	57	4.7
4. Judicially separated	12	1.6	6	1.3	18	1.5
5. Non-judicially separated ...	27	3.6	19	4.1	46	3.8
6. Divorced	26	3.5	17	3.7	43	3.6
7. Cohabiting ...	9	1.2	4	0.9	13	1.1
8. Not known	13	1.7	7	1.5	20	1.7
Totals	758		470		1,228	

A few entries have been made under more than one heading. Hence percentages exceed 100.

Table 63. *Marital Status of Parents of* 1,211 *Children.*

It will be seen from table 63 that broken marriages (Nos. 3—6) amount to 164 (13.6 per cent). Of these 107 (8.9 per cent) were terminated otherwise than by death. Both figures are smaller than the corresponding figures for adults, namely 18.8 per cent of broken marriages and 11.3 per cent of marriages broken otherwise than by deaths (table 5).

Parents married more than once.

Of, 1,211 children, 25 had unmarried parents. Hence the parents of 1,186 children were married once or more often—how often was unknown of 51. There remain 1,135 children of whose parents the information is available. Of these—

1,040 (91.6 per cent) were married once only; and
95 (8.4 per cent) were married more than once.

The figure is closely similar to that of 7.1 per cent for adult patients (table 8).

4. Religions of Parents.

The distribution is shown in table 64:

Religious Affiliation	Boys		Girls		Totals	
	No.	%	No.	%	No.	%
Church of England ...	579	79.0	379	83.7	958	80.8
Roman Catholic ...	99	13.5	50	11.0	149	12.6
Nonconformist ...	7	1.0	6	1.3	13	1.1
Jewish	21	2.9	10	2.2	31	2.6
Other	44	6.0	11	2.4	55	4.6
Total Parents	750		456		1,206	
Total Children ...	733		453		1,186	
Not known	14		11		25	
Total Children ...	747		464		1,211	

Table 64. *Religious Affiliations of parents.*
1,211 Children.

Twenty children had parents of different religions. Hence the number of parents whose religions are recorded exceeds by twenty the total number of children (1,186) whose parents' religions were known. The percentages therefore exceed a hundred.

It will be seen that the parents of four out of five children belong to the Church of England. Over twelve per cent were Roman Catholics a figure which exceeds that given by the *Catholic Directory* (1955) for the country as a whole (seven per cent). The excess of Roman

Catholics among the parents of our child-patients is more likely to be caused by a local excess of Roman Catholics living in certain areas of South London from which patients are sent to us than by a differential incidence of disturbances among children connected with the religious affiliations of their parents.

A comparison with the distribution of religious denominations among adult patients (table 9) shows that among the latter there were relatively more Nonconformists than among the parents of children (6.4 against 1.1 per cent); there were also more adult patients of Jewish faith than parents of children (4.5 against 2.6 per cent). On the other hand, there were relatively fewer members of the Church of England among adult patients (74.1 against 80.8 per cent). Though the numbers are too small to draw conclusions, it is not entirely impossible that the stronger religious beliefs held by most Nonconformists and Jews (both minorities) compared to most members of the Church of England, many of whom are lukewarm or indifferent to religion, may provide a better moral discipline for children than the more conventional creed as practised in the home. On the other hand, the minority religion, if strictly adhered to, may present certain emotional problems to adults. Further information about larger child patient-populations is needed. The populations from which the Hospital's adult and child patients are drawn are generally similar in respect of occupation and social class.

5. Weekly Income.

Weekly Income	No.	%
Over £12 ...	84	10.5
£7—12 ...	316	39.9
£4—7 ...	377	47.1
Under £4 ...	20	2.5
Total known ...	797	100.0
Not known ...	414	—
Total	1,211	—

Table 65. *Weekly Income of Parents.*
797 Children: Four Brackets.

It will be seen from table 65 that information was available of the parents of only 797 children (66 per cent). The high proportion of "not known" cases is the same as that of adult patients (table 16). Comparison of the two tables shows that the weekly incomes of the children's parents are somewhat higher than those of adult patients.

The fact should not be overlooked that among the adult patients is a substantial fraction of single patients and of younger patients; and that, in recording the weekly income, the total income from all sources is asked for, so that if a mother is earning, her contribution is included. Likewise included are family and other allowances. The next table (66) affords a better comparison of the socio-economic status of adult patients and the parents of the children. Table 65 does not suggest that the parents of our children live in excessive poverty.

6. Social Class.

		Social Class					Not known
		I	II	III	IV	V	
Inpatients—							
Boys (145)		3.4	15.9	53.1	11.7	15.9	8
Girls (91)		5.5	12.1	57.1	11.0	14.3	6
Outpatients—							
Boys (558)		3.8	13.3	59.5	14.0	9.4	36
Girls (339)		3.8	10.6	60.5	15.3	9.8	28
Totals	No. (1,133)	44	144	666	157	122	78
	Percentage	3.9	12.7	58.8	13.9	10.7	

Table 66. *Social Class of Parents.*
1,133 Children.

Of the total of 1,211 patients, information on social class was not available for 78. The above table is therefore based on 1,133 children (a 94 per cent sample).

A comparison of table 66 with table 15, (page 27) which gives the distribution of adult patients by social class, shows no substantial difference. The distribution is more median than that of the males of Greater London (table 15).

As is to be expected, the difference in respect of social class between adult in- and outpatients is not reproduced among the parents of the children.

7. Ages of Mothers at First Marriage and at Birth of Patients.

Of the total of 1,211 children, 25 had parents who were unmarried, and in respect of as many as 412 the age at which the mother was first married was either not recorded or recorded as not known. There remain 799 children in respect of whom the ages of their mothers at first marriage is known (a 66 per cent sample). There are 1,058 mothers whose ages when the patients were born are known (87 per cent sample). Table 67 shows the age-distribution of these two groups of mothers.

Age of Mother	Age at first marriage (799 mothers)		Age at birth of patient (1,058 mothers)	
	No. of mothers	%	No. of mothers	%
Under 20	170	21.3	45	4.3
20—24	394	49.3	312	29.5
25—29	174	21.8	340	32.1
30—34	49	6.1	210	19.8
35—39	11	1.4	111	10.5
40—44	—	—	37	3.5
45 and over	1	0.1	3	0.3
	799	100.0	1,058	100.0

Table 67. *Ages of Mothers at First Marriage* (799 *Mothers*) *and at Birth of Patients* (1,058 *Mothers*).

The ages of the mothers at first marriage have been tabulated (the table is not here shown) by the ages of the children. The latter are divided into three age-groups, namely 0—4, 5—9, and 10—15.

There is no noteworthy difference between the ages at first marriage of the mothers of the children in these three groups; for all three the mother's average age is 24. Comparison of table 67 with table 11 (page 21), which gives the age at marriage of adults, shows that the mothers of the children married on average at about the same age as did the female adult patients who were married (24.8 years).

For the whole group, the average age of the mothers at the births of the patients was 28, thus suggesting an average interval (for the two sets of figures are dissimilar between the mother's age at first marriage and her age at the birth of the patient) of about four years. This interval seems rather long.

8. Number of Children Born Alive to Patients' Mothers.

The size of the sibships of which our children form part are influenced by the ages of their mothers. Many of these are still young and will bear further children. An assessment of their completed fertility must therefore make allowance for the future. Such allowance, when made, suggests that the children's mothers are more fertile than the average.

We would expect that the mothers of children under four would, on average, be younger than the mothers of children over ten; that their fertilities would be further from completion; and that they would have had fewer children. The last expectation is born out as shown in table 68. Information (table 68) is available, as to the number of children *born* alive to 1,156 mothers; and, as to the number of children alive during the triennium, of 1,154 mothers.

Age of Children	Number of Children (including patient) of patients' mother	
	Born alive (1,156 mothers)	Alive 1949–1951 (1,154 mothers)
0— 4	2.2 (1.6)	2.1 (1.6)
5— 9	2.8 (2.1)	2.7 (2.0)
10—15	3.4 (2.4)	3.1 (2.3)
Average	3.1 (2.2)	2.9 (2.1)

Table 68. *Fertility of Childrens' Mothers.*

Number of Children Born Alive and Alive during the Triennium according to Ages of Children: Three age-groups. Corrected Figures in Brackets. (See text).

The figures in brackets (table 68) show the family size when corrected in the same manner as are the figures for the sibships of adult patients given in table 12b. (This correction removes the bias, to which Greenwood and Yule drew attention, which causes the average size of families in a hospital sample to appear larger than it is).

It will be seen from table 68 that, during the period 1949-51, which is covered by the report, the average child belonged to a sibship of 2.1 (corrected): in other words, he had one live brother or sister.

How do these figures compare with those for the general population? A not entirely satisfactory comparison is afforded by the 1951 census. This tells us the average number of children aged under 16 in the families of Greater London (Table 69).

No. of Children per Family	Census: Children under 16	1,154 Maudsley children
1	51.6	17.0 (37.0)
2	33.1	32.7 (35.5)
3—4	13.7	32.1 (21.0)
5+	1.6	18.1 (6.5)
Average No.	1.7	2.9 (2.1)

Table 69. *Fertility of Childrens' Mothers.*

Sizes of Sibships comprising 1,154 Children compared with Sibships containing Children under 16 in Greater London. Corrected Figures in Brackets.

But the comparison is invalidated by two circumstances: the first is that the figures for London exclude children over 16 who are included in the sibships of the Maudsley children; the second is that our sample is heavily biassed by the numerical preponderance of children aged 10—15. If the London sample had been restricted to such children, the resultant figure would have been somewhat larger.

But despite these shortcomings, the comparison suggests that the sibships to which our children belong are larger than the average. It can be seen from table 68 that children who were aged under four (of whom there were 109) belonged to sibships of 1.6 (corrected) children which correspond with the figure of 1.7 for Greater London. The average figure of 2.1 (corrected) children born alive to the mothers of child patients will probably be exceeded when the reproductive lives of these mothers are completed. It was earlier mentioned that the average age of the mothers at marriage was 24 and at the patient's birth 28. Forty-six per cent of the children were under ten; and a comparison (table 68) of the size of sibships containing children under 4 with those over 10, shows that the fertility of our children's mothers is incomplete.

9. Mental State of Mother.

Of the mothers of 366 out of the 1,211 children (30 per cent) the mental state was not recorded. It was assessed and recorded of the mothers of 845 children as shown in table 70:

Mental state of mother	No.	%
Normal	484	57.3
Unstable	274	32.4
Mentally retarded	24	2.8
Psychiatrically treated ...	63	7.5
Totals	845	100.0

Table 70. Mental State of the Mothers of 845 children.

The percentages of normal and abnormal conditions among the parents of boys and girls, which are not separately shown in table 70, are closely similar. It should be understood that these assessments are subjective; they are made by the doctors and social workers and might therefore be regarded by some as unreliable.

It will be seen that 43 per cent of mothers are assessed as other than normal (32 per cent as unstable). This large fraction has remained rather surprisingly consistent during the three separate years of the triennium.

10. Patients who are Twins.

Among 1,211 children, twenty-six had twins. These were as follows, the percentages being of all child patients:

	No.	%
Sex of twin not known - -	1	0.2
Twin same sex - - -	15	1.3
Twin of different sex - -	12	0.9
Total - - - -	28	2.4

11. Patients whose Parents are First Cousins.

Information was lacking about the parents of 75 of the 1,211 children. Of the remaining 1,136 children, six (0.6 per cent) had parents who were first cousins.

12. Step- or Foster-mother Responsible for Child.

Of the 1,211 children, information was not available about two. Of the remaining 1,209 children, a step- or foster-mother was responsible for 162 (13.4 per cent: 12.4 per cent of boys and 14.1 per cent of girls).

The proportion, which seems large, raises the question of how far the child's disturbance was respectively caused by a specific step- or foster-mother situation or by involvement in the tangle of genetic and environmental factors which lead to broken marriages.

13. Previous Admissions.

Number of previous admissions	Inpatients (284)		Outpatients 985)	
	Boys (170)	Girls (114)	Boys (610)	Girls (375)
None	38.2	35.0	91.5	92.5
One	53.0	51.8	7.5	6.7
Two	5.9	3.5	1.0	0.5
Three	1.8	5.3	—	0.3
Four or more	1.1	4.4	—	—
Total	100.0	100.0	100.0	100.0
Admission Ratio	172	194	110	109

Table 71. *Previous Admissions at any Time to Wards or Outpatient Department of* 1,269 *Children* (*Discharges*).

Previous admissions of inpatients (table 71) were much more numerous than for outpatients: 63 per cent compared with 8 per cent had previously been admitted. Previous admissions of girl *in*patients were more numerous than of boys, the admission ratio (explained on page 68) being 194 for girls compared with 172 for boy inpatients (bottom line). In this respect girls resemble adult women patients (table 49, page 67). Previous admission of boys and girls as *out*patients was much the same (ratio of 110 compared with 109).

There is an administrative reason for the higher admission ratio of girl compared to boy inpatients. Normally a child is first seen as an outpatient before admission. Exceptions are emergencies and patients who live far away. The greater urgency of behaviour problems among boys compared to girls increases the likelihood of an emergency or of a child referred from a distance being a boy. Hence fewer boy than girl inpatients had previously been admitted to the outpatient department, and the boys' admission ratios were lower.

It is of interest to compare the admission ratio of children with that of adults. The total 1,269 discharged children had been admitted 1,595 times counting the current admission as one. These figures yield an admission ratio of 126 which can be compared to that of 160 for 8,295 adult patients (table 49). The smaller ratio for children is in accordance with expectation.

14. Relatives of Children Treated at Joint Hospital.

Of the total of 1,269 discharges, the information was not known of 70. Of the remaining 1,199 children, 151 (12.6 per cent) had relatives treated at the Joint Hospital. The proportion is double that occurring among adult patients, namely 6.8 per cent (table 20, page 35). Of 1,207 children, 98 (8.1 per cent) had sibs who had been treated in the Children's Department.

These figures of 12.6 per cent for relatives and 8.1 per cent for sibs treated at the Joint Hospital seem high; but it should be recalled that referrals from one hospital department to the other sometimes occur.

15. Referring Agencies: Inpatients.

Referring Agency	Boys		Girls		Total	
	No.	%	No.	%	No.	%
1. From outpatient dept. ...	95	56.0	64	55.9	159	56.0
2. Child guidance unit outside	20	11.7	10	8.8	30	10.5
3. Psychiatric unit or dept. of general hospital ...	17	10.0	9	7.9	26	9.2
4. Non-psychiatric hospital or department	10	5.9	5	4.4	15	5.3
5. Other sources specified below	21	12.4	18	16.0	39	14.0
6. Other sources unspecified...	4	2.9	5	4.4	9	3.2
7. Private doctors	4	2.4	3	2.6	7	2.5
Total referrals	171		114		285	
Total patients	170		114		284	

Table 72. Referring Agencies.
284 Inpatients (Discharges).

Item 5 in table 72 refers to specified sources. Thirty-nine children (14.0 per cent) were so referred by thirteen agencies, none of which sent more than five children. They were as follows (the number of children referred by each is given in brackets): Outside consultant (5), Local Education Authorities other than London County Council (5), Spontaneous (5), Research Depts. of Joint Hospital (4), Voluntary organisations (3), L.C.C. Children's Committees (3), Probation Service, Remand Home or Court (3), Ministry of Health (2), Observation wards (2), Consultant psychiatrist on Joint Hospitals staff (2), Mental Hospitals (2), Joint Hospital Domiciliary Service (2) and Home Office (1).

It will be seen (totals column) that over 75 per cent of cases were referred by the three first-mentioned agencies.

Relatively more boys than girls were sent by the first four agencies listed and more girls than boys by the three last named. But numbers are small and differences not statistically significant.

16. REFERRING AGENCIES: OUTPATIENTS.

Referring Agency	Boys		Girls		Totals	
	No.	%	No.	%	No.	%
1. Private Doctor	169	24.7	111	25.0	280	24.9
2. L.C.C. Children's Committee	117	17.1	66	14.9	183	16.3
3. General Hospital: Non-psychiatric...	68	9.9	58	13.1	126	11.2
4. Probation Service, Remand Home, Court	88	12.9	29	6.6	117	10.4
5. Psychiatric Unit or Dept. of General Hospital ...	42	6.1	21	4.8	63	5.6
6. Child Guidance Unit ...	33	4.8	26	5.9	59	5.2
7. Ex-Inpatients	18	2.6	24	5.4	42	3.7
8. Local Education Authorities (other than L.C.C.) ...	21	3.1	18	4.1	39	3.5
9. Other Voluntary Organisations	11	1.6	13	2.9	24	2.1
10. Consultant Joint Hospital Staff	9	1.3	6	1.4	15	1.3
11. Consultant outside ...	10	1.5	—	—	10	0.9
12. Other Sources specified below	21	3.0	14	3.2	35	3.2
13. Other Sources unspecified	80	11.7	56	12.7	136	12.1
Total referrals	687		442		1,129	
Total patients	684		442		1,126	

Table 73. *Referring Agencies*: 1,126 *Outpatients* (*Discharges*).

A comparison of table 73 with table 22 (page 37), which gives referring agencies for adult patients, shows pronounced differences, all to be expected. Private doctors, who referred a quarter of the

children, sent 61 per cent of adults; ex-inpatients, who formed under four per cent of children, constituted fourteen per cent of adult outpatients. Agencies such as the L.C.C. Children's care committee, the probation service, remand homes, courts, child guidance units and local education authorities, which are concerned with the behaviour problems and home environments of children, and which have but scanty equivalents among adults, sent over a third of the children.

Child Patients were drawn from a wider geographical area than adults. Of inpatients some 60 per cent, and of outpatients some 25 per cent came from outside the London County area.*

Item 12 above refers to specified sources. Thirty-five patients were so referred—21 boys and 14 girls. They were sent by the following nine agencies none of which referred more than seven patients (the numbers being given in brackets): Ministry of Health (7), Spontaneous Cases (7), Home Office (5), Joint Hospital Domiciliary Service (4), Mental Hospitals (3), Research Departments (3), Assistance Institutions (3), Ministry of Education (2), Observation ward (1).

* In Chapter 2 the demographic, social and economic features of the hospital population were compared with those of the population of Greater London. The Joint Hospital's catchment area is further discussed in Chapter 6.

17. Duration of Stay of Inpatients.

	Year	Period of stay in hospital: months								Total children
		Under One	2	3	4-5	6-8	9-12	Over twelve	Mean mths.	
170 Boys	1949	12	11	5	12	3	1	1	3.0	45
	1950	11	14	8	17	8	6	3	4.3	67
	1951	7	6	7	11	14	8	5	6.3	58
	1949-51	30	31	20	40	25	15	9	4.9	170
114 Girls	1949	11	6	5	7	1	—	1	2.7	31
	1950	13	11	9	7	3	4	2	3.7	49
	1951	4	3	7	6	8	5	1	6.3	34
	1949-51	28	20	21	20	12	9	4	4.2	114

Table 74. *Duration of Stay of* 284 *Inpatients* (*Discharges*) *by Years* 1949, 1950 *and* 1951 *separately shown.*

It will be seen from table 74 that the average duration of stay over the triennium as a whole was 4.9 months for boys and 4.2 months for girls. These periods are longer than those for adult patients—3.6 months for males and 4.0 for females (table 23, page 39).

Table 74 further shows that the average duration of stay of children inpatients has increased year by year: in 1951, it was twice as long (being over six months) for both boys and girls as in 1949 (three months for boys and less for girls).

18. NUMBER OF TIMES SEEN: OUTPATIENTS.

No. of times seen		Percentages		
		Boys (684)	Girls (442)	Totals (1,126)
Once	(313)	29.2	25.8	27.7
Twice	(108)	8.5	11.3	9.6
Three times	(77)	6.4	7.5	6.8
Four times	(68)	6.8	4.8	6.0
5—6 times	(106)	7.6	12.2	9.4
7—9 times	(132)	10.5	13.6	11.8
10—12 times	(99)	9.6	7.5	8.8
13—18 times	(114)	10.9	8.8	10.2
19—25 times	(56)	5.3	4.5	5.0
More than 25 times	(53)	5.2	4.0	4.7
Totals	(1,126)	100.0	100.0	100.0
Average No. of times seen		8.0	7.3	7.7

Table 75. Number of Times Seen: 1,126 *Outpatients* (*Discharges*)

Some of the comments made on table 24 (pages 39-40), which deal with the number of times that adult patients were seen in the outpatient department, are here applicable.

Children outpatients pay many more visits to the hospital than adults. The average numbers of times seen, which are shown for children on the bottom line of table 75, are, for adults, 3.3 for males, 3.0 for females and 3.1 for both combined. Children thus attend more than twice as often as adults.

Every child is investigated in respect of physical state, intellectual capacity and mental health; and in addition the family, social and educational situation is explored. Treatment and remedial measures in every field are forthwith undertaken wherever appropriate. Children seen once only (28 per cent of total referrals) were mostly referred from a clinic at some distance from the Maudsley hospital (such as delinquents brought before a court), or else they failed (lapsed) after the first interview. Of the remaining majority, comprehensive treatment is continued until the unit is satisfied that everything possible has been done for the child or until the parents cease to bring the child.

It will be seen that half the children (49.9 per cent) attend the hospital more than four times compared with 16.1 per cent of adult patients (table 24).

19. Special Investigations: Inpatients.

The nature and number of special investigations performed on children are of some interest partly because they throw light on the activities of the children's department of the Joint Hospital, and partly because they reflect on the need for accessory services, such as those of psychologists, and for laboratory services.

Special investigation	Boys		Girls		Totals	
	No.	%	No.	%	No.	%
A. PHYSICAL TESTS.						
Electroencephalogram ...	126	74.1	77	67.5	203	71.8
X-rays	50	29.4	21	18.4	71	25.0
Wasserman or Kahn test ...	35	20.6	26	22.8	61	21.5
Blood count	35	20.6	22	19.3	57	20.1
Erythrocyte sedimentation test	35	20.6	20	17.5	55	19.4
Other special biochemical tests	27	15.9	16	14.0	43	15.1
Bacteriological tests ...	10	5.9	7	6.1	17	6.0
Other somatic investigations	7	4.1	6	5.3	13	4.6
Electrocardiogram ...	3	1.8	9	7.9	12	4.2
Glucose tolerance and insulin	4	2.4	5	4.4	9	3.2
Cerebro-spinal fluid ...	5	3.0	3	2.6	8	2.8
Basal metabolic rate ...	5	3.0	2	1.8	7	2.5
Other microscopical tests ...	3	1.8	3	2.6	6	2.1
Other immunity tests ...	4	2.4	1	0.9	5	1.8
Biopsy	1	0.6	1	0.9	2	0.7
B. PSYCHOLOGICAL TESTS.						
Verbal intelligence tests ...	122	71.8	80	70.2	202	71.2
Non-verbal intelligence tests	125	73.5	68	59.6	193	68.0
Projection tests	25	14.7	27	23.7	52	18.3
Tests of deterioration ...	7	4.1	6	5.3	13	4.6
Differential aptitude tests ...	9	5.3	1	0.9	10	3.5
Other psychological tests ...	37	21.8	6	5.3	43	15.1
C. OTHER PROCEDURES.						
Opinion of specialist sought	46	27.1	31	27.2	77	27.1
No special test of investigation	9	5.3	10	8.8	19	6.7
Number of patients to whom above investigations refer ...	170		114		284	

Table 76. Special Investigations performed on 284 Inpatients (Discharges).

In table 76 the physical investigations are given first, in a descending order of frequency of the total tests; psychological tests are then considered.

It will be seen from table 76 that, when admitted as inpatients, children are thoroughly investigated. Over 70 per cent are electroencephalographed, a quarter are X-rayed and a fifth have Wasser-

man or Khan tests. Verbal and non-verbal intelligence tests are performed on about 70 per cent. Under seven per cent undergo no special test or investigation.

20. Outcome of Treatment.

Condition when discharged	Boys (170)	Girls (114)	Totals (284)
1. Recovered or much improved (106)	35.8	39.4	37.2
2. Improved or slightly improved (112)	39.4	39.5	39.5
3. No change, worse or died (66) ...	24.8	21.1	23.3
	100.0	100.0	100.0

Table 77. Outcome of Treatment: 284 Inpatients (Discharges).

The above results, if compared with those of adults (table 27, page 43), are seen to be slightly less favourable. Of adults, 47 per cent left recovered or much improved against 37 per cent of children.

But as with adults, the results are somewhat better with girls than boys, the percentage of girls in the first group being a little higher, and in the third group correspondingly lower than that of boys.

The less favourable results, compared with adults, reflect the fact that, to require admission, a child is commonly more severely ill than an adult. For several reasons, among them the lack of alternative provision, there are admitted to the childrens' department severe and chronic cases the adult equivalents of which would frequently be referred elsewhere.

24. Disposals.

(*a*) *Inpatients.*

The disposals, which were multiple, are arranged (table 78) in four main groups as for adults (table 28, page 44). About twelve per cent of children were referred to their private doctors and about half for further treatment or supervision at the Joint Hospital. An appreciably larger proportion than among adults (22.6 against 10.9 per cent) were referred for residential treatment elsewhere. Eleven per cent of children compared with 14 per cent of adults were discharged (or removed by their parents) against advice; more girls (17.5 per cent) than boys (7 per cent) were so removed.

More boys than girls (28.3 against 14.1 per cent) were referred for outside residential treatment. The miscellaneous disposals (tenth

on the list), sixty-eight in number and amounting to 24.1 per cent, were as follows (the numbers of children being given in brackets): Letter to Social Agencies (42), Letter to Probation Officer or Remand Home (7), Referred to Disablement Resettlement Officer (4), Referred to a psychiatrist in private practice (2), Letter to Home Officer (1), other disposals (12).

Disposals (multiple)	Percentages		
	Total (284)	Boys (170)	Girls (114)
A. 1. To Private Doctor	11.6	11.8	11.4
B. *Further treatment or supervision at Joint Hospital.*			
2. To outpatient dept. for regular treatment...	14.8	15.9	13.2
3. To O.P.D. for follow up ...	29.2	26.5	33.3
4. To clinic for epilepsies	8.5	9.4	7.0
	52.5	51.8	53.5
C. *Residential Treatment outside hospital.*			
5. Admission to residential institution (non-hospital)	16.9	21.2	10.5
6. Admission recommended to non-psych. unit or hospital	3.5	4.7	1.8
7. Admission to mental hospital as V.P. recommended	1.8	1.8	1.8
8. Admission to psych. unit outside recommended	0.4	0.6	—
	22.6	28.3	14.1
D. *Other Disposals.*			
9. Referred to psychiatric department outside	10.2	11.8	7.9
10. Miscellaneous (see above) ...	24.1	26.6	20.2
11. Discharged against advice ...	11.3	7.0	17.5
	45.6	45.4	45.6

Total Disposals: 374 Disposals (Boys 232, Girls 142) of 284 patients. The disposals being multiple, the percentages exceed 100.

Table 78. *Disposals*: 284 *Inpatients* (*Discharges*).

(*b*) *Outpatients.*

Table 79 differs from table 29 (page 45), which gives the disposal of adult outpatients, mainly in the proportion of cases for whom admission to a hospital or institution is recommended. The figures are 34 per cent for adults and 11.8 per cent for children. The smaller figure for children is mainly the expression of the preferability of treating children as outpatients, without removing them from their families.

Disposals (multiple)	Percentages		
	Totals (1,126)	Boys (684)	Girls (442)
A. 1. *Referred to private doctor.* ...	31.1	30.4	32.1
B. *Admission to hospital or institution recommended.*			
2. Admitted to Maudsley hospital	11.2	10.5	12.2
3. Admission recommended to non-psychiatric hospital	0.2	—	0.5
4. Admission recommended to residential institution	0.2	0.3	—
5. Admission recommended to observation ward	0.2	—	0.5
	11.8	10.8	13.2
C. *Further treatment or disposal elsewhere recommended.*			
6. Referred to outside psychiatrist	5.9	5.4	6.1
7. Referred to D.R.O.	0.4	0.4	0.2
8. Referred to Joint Hospital's clinic for epilepsies	0.2	0.3	—
9. Referred to Joint Hospital's adult department	0.1	—	0.2
	6.6	6.1	6.5
D. *Other Disposals.*			
10. Letter to probation officer or remand home	10.2	12.6	4.3
11. Letter to other social agencies ...	30.2	31.3	28.7
12. Letter to Home Office or other government department ...	1.4	1.6	1.1
13. Other disposal	5.0	5.1	4.8
14. No special disposal	13.5	11.4	16.7
	60.3	62.0	55.6

Multiple Disposals: Hence percentages add up to more than 100.

Table 79. *Disposal*: 1,126 *Outpatients* (*Discharges*).

22. Mode of Leaving: Outpatients.

The observations made on table 31 relating to adults (page 47) here in part apply. In table 80, the percentages in the first two categories are closely similar for boys and girls. Just under a quarter of outpatients lapse—more than among adults (19 per cent).

The apparently high lapse rate of 25 per cent is largely due to the time-consuming demands made on mothers by the numerous attendances with the child at the outpatient department (twice as numerous for children as for adults: see table 75). These exacting requirements reflect a reluctance on the part of the medical staff of the Children's Department to discharge a child with any residual symptoms.

Mode of Leaving	Boys (684)	Girls (442)	Totals (1,126)
Discharged	75.4	75.1	75.3
Lapsed	24.6	24.4	24.5
Died	—	0.5	0.2
	100.0	100.0	100.0

Table 80. *Lapses among* 1,126 *Outpatients* (*Discharges*).

Follow-up studies have shown that lapses of attendance on the part of mothers by no means necessarily imply dissatisfaction with the progress of treatment. On the contrary, it often implies that the mother's standards of recovery or of normality are less exacting than the hospital's.

23. Follow-up and Social Case Work.

Of 1,126 outpatients, 257 (22.7 per cent) were recorded as requiring to be followed up. This is just under double the figure for adults (11.7 per cent), and is closely similar to the lapse-rate (24.5 per cent).

Of 284 inpatients, social case-work was undertaken for 193, or 68 per cent; of 1,126 outpatients, the same was done for 491, or 43.6 per cent. (The corresponding percentages for adults are (inpatients) 44.7 and (outpatients) 17.7).

CHAPTER SIX.

PRACTITIONERS REFERRING PATIENTS TO THE JOINT HOSPITAL: YEARS 1949, 1950 and 1951.

In the following tables, the total number of patients recorded as having been dealt with each year are solely those referred to the hospital by general practitioners. Patients referred to the hospital through other channels are not included.

The total figures are thus smaller than those given in preceding tables. The residences of practitioners and patients are those denoted by their addresses.

By the London area is here meant the London Postal Area which includes elements of the counties contiguous to the County of London.

		Practitioners			Patients		
	Residence of Practitioners	1949	1950	1951	1949	1950	1951
Numbers	London Postal area ...	495	551	595	1,197	1,495	1,602
	Counties	137	141	181	194	232	247
	Abroad	—	4	2	—	4	2
	Total	632	696	778	1,391	1,731	1,851
Per cent.	London Postal area ...	78	80	76	86	86	87
	Counties	22	20	24	14	14	13
	Total	100	100	100	100	100	100

Table 81. *General Practitioners referring Patients to the Joint Hospital and the Patients thus referred classified by Residences of Practitioners (London, Counties and abroad). Numbers and Percentages.*

The following points in table 81 are noteworthy:

(1) The number of *General Practitioners* referring patients has steadily increased over the three years. The number in 1951, (778) is 11 per cent higher than in 1950 (696), and the number in 1950 is 10 per cent higher than that in 1949 (632).

(2) The number of *patients* referred by general practitioners has likewise increased by a little over 10 per cent in each year.

(3) In 1951, 3 out of 4 (76 per cent) referring doctors practised in the London area; 1 in 4 (24 per cent) in the counties.

(4) In 1951 about 7 patients out of 8 (87 per cent) lived in the London area, and 1 in 8 (13 per cent) in the counties. The different proportion of doctors and of patients residing in the London area is accounted for by the fact that doctors in London refer more patients per doctor than those practising in the counties.

(5) The percentages of doctors and patients residing in London compared to the percentages residing in counties and abroad has changed little throughout the three years (76—80 per cent of doctors, and 86—87 per cent of patients resided in London).

	London Postal district	Practitioners			Patients		
		1949	1950	1951	1949	1950	1951
Numbers	S.E.	223	243	260	644	782	830
	S.W.	144	155	168	376	418	479
	Total	367	398	428	1,020	1,200	1,309
	W.	50	51	69	75	133	142
	W.C.	5	9	3	5	11	4
	E.	24	24	31	31	59	63
	E.C.	1	1	1	1	1	1
	N.	18	28	30	20	33	32
	N.W.	30	40	33	45	58	51
	Total	128	153	167	177	295	293
	TOTAL	495	551	595	1,197	1,495	1,602
Per cent.	S.E. and S.W.	74	72	72	85	80	82
	Other London Postal Districts	26	28	28	15	20	18
	Total	100	100	100	100	100	100

Table 82. *Referring doctors practising in London Postal Area and patients referred by them classified by postal districts. Numbers and percentages.*

Table 82 gives an analysis by postal district of the practitioners and patients residing in the London Postal Area. The following points are noteworthy:

(1) About 7 out of 10 London doctors (72 per cent in 1951) and 8 out of 10 London patients (82 per cent in 1951, live in the South of London, i.e. in the S.E. and S.W. districts, on the boundary between which the Maudsley Hospital is situated.

(2) If we treat doctors and patients living in S.E. and S.W. London, as "local", a comparison of tables 81 and 82 will show that, in 1951, 428 out of 778 doctors (or 55 per cent), and 1,309 out of 1,851 patients (71 per cent) were "local". These percentages (55 per cent and 71 per cent) express how far the hospital serves local doctors and patients.

(3) In the course of the three years under review, there has been little change (no perceptible trend) in the proportion of "local" doctors and patients served. The percentage for 1951 of "local" doctors (72) and of "local" patients (82) are close to the percentages for the two previous years.

County	Doctors			Patients		
	1949	1950	1951	1949	1950	1951
Kent	51	43	64	88	111	112
Surrey	25	37	44	37	57	57
Middlesex	11	13	21	16	14	24
Sussex	6	4	7	6	4	8
Herts.	4	6	4	4	7	4
Essex	10	4	12	10	4	12
Notts.	—	1	1	—	1	1
Beds.	4	—	1	7	—	1
Norfolk...	—	1	2	—	1	2
Suffolk	3	2	3	3	2	3
Cambridge	—	1	2	—	1	2
Warwick	—	2	1	—	2	1
Bucks.	—	1	2	—	1	2
Somerset	2	1	—	2	1	—
Dorset	4	—	1	4	—	1
Devon	4	3	2	4	3	3
Cornwall	1	1	1	1	1	1
Northants.	2	1	—	2	2	—
Hants.	4	4	2	4	4	2
Berks.	1	3	1	1	3	1
Lincoln	1	1	1	1	1	1
Staffs.	1	—	—	1	—	—
Yorks.	1	2	2	1	2	2
Lancs.	1	2	1	1	2	1
Worcester	—	1	—	—	1	—
Gloucester	—	5	1	—	5	1
Cheshire	—	—	1	—	—	1
Isle of Wight	—	1	—	—	1	—
Isle of Man	1	—	1	1	—	1
Wales	—	1	2	—	1	2
Scotland	—	—	1	—	—	1
	137	141	181	194	232	247
No. of Counties ...	20	25	26	20	25	26

Table 83. *General Practitioners referring Patients to the Joint Hospital and the Patients thus referred distributed by Counties* (*London Postal Area excluded*).

Table 83 shows the distribution over the three years of doctors and patients in the counties outside London (Scotland, Wales, Isle of Wight and Isle of Man are here treated as counties).

(1) Doctors in 26 counties were served in 1951 compared with 25 counties in 1950 and 20 in 1949 (bottom line of table).

(2) Forty more doctors referred patients in 1951 (181) compared to 1950 (141); four more in 1950 (141) than in 1949 (137).

(3) Kent easily tops the list in all three years, showing most referring doctors and referred patients.

(4) Throughout the three years Kent and Surrey between them contain more than half the totals of referring doctors and referred patients from the counties.

How many doctors practising in South London, who could be regarded as local doctors, might have sent patients to the Joint Hospital but did not do so? A strictly accurate answer is not possible; but an approximate answer, which, if it errs, does so by under-estimating the number, is available.

The London Executive Council publishes at short intervals lists of doctors practising in the Metropolitan Boroughs comprised in the County of London. South of the Thames, the County of London is not exactly coterminous with the S.E. and S.W. postal districts, being for the most part smaller in so far as the postal districts include elements of the adjacent counties. But the number of doctors referring patients to the Joint Hospital who practise in those areas of the S.E. and S.W. postal districts which fall outside the County of London boundary is sufficiently small to be negligible for the purpose here in view.

Area of Doctors' Practice		Total No. of Doctors practising in S.E. and S.W. Areas of County of London			S.E. and S.W. Postal Districts: Number of Doctors referring patients to Joint Hospital			Percentage of Doctors using Joint Hospital of all doctors in the Areas		
		1949	1950	1951	1949	1950	1951	1949	1950	1951
S.E. London ...	a	637	651	651	223	243	260	35.0	37.4	40.0
S.W. London ...	b	770	809	809	144	155	168	18.6	19.2	21.0
Total	c	1,407	1,460	1,460	367	398	428	26.1	27.3	29.0

Table 84. *Doctors practising in S.E. and S.W. Postal Districts of London who referred Patients to the Joint Hospital shown as Percentages of all Doctors practising in S.E. and S.W. County of London Areas.*

Table 84 compares the numbers of doctors practising in the S.E. and S.W. London Postal Districts who actually sent patients to the Joint Hospital with the numbers of doctors recorded in the London Executive Council's lists as practising in those Metropolitan Boroughs which are included in the S.E. and S.W. postal districts. These are all "local" doctors who might have sent patients to the Joint Hospital if they had felt so disposed.

No. of Patients referred by each doctor.	S.E. Postal District						S.W. Postal District					
	1949		1950		1951		1949		1950		1951	
	Drs.	Pts.	Drs.	Pts.	Drs.	Pts.	Drs.	Pts.	Drs.	Pts.	Drs.	Pts.
1	79	79	96	96	86	86	70	70	72	72	81	81
2	55	110	50	100	71	142	20	40	31	62	32	64
3	28	84	26	78	27	81	17	51	19	57	15	45
4	24	96	14	56	25	100	16	64	8	32	11	44
5	14	70	15	75	13	65	5	25	7	35	9	45
6	5	30	14	84	9	54	9	54	4	24	4	24
7	4	28	5	35	7	49	1	7	2	14	5	35
8	4	32	5	40	3	24	1	8	3	24	4	32
9	3	27	2	18	3	27	1	9	3	27	1	9
10	1	10	2	20	3	30	1	10	3	30	3	30
11	2	22	6	66	4	44	—	—	1	11	—	—
12	2	24	4	48	3	36	1	12	—	—	—	—
13	1	13	—	—	3	39	2	26	—	—	1	13
14	—	—	1	14	1	14	—	—	1	14	1	14
15	—	—	1	15	—	—	—	—	—	—	—	—
16	—	—	—	—	—	—	—	—	1	16	—	—
17	—	—	1	17	—	—	—	—	—	—	—	—
18	—	—	—	—	1	18	—	—	—	—	—	—
19	1	19	—	—	—	—	—	—	—	—	—	—
20	—	—	1	20	—	—	—	—	—	—	—	—
21	—	—	—	—	1	21	—	—	—	—	—	—
43	—	—	—	—	—	—	—	—	—	—	1	43
Totals ...	223	644	243	782	260	830	144	376	155	418	168	479

Table 85. Referring Doctors and Patients referred by them. S.E. and S.W. Postal Districts of London. Number of Referrals by Individual Doctors.

The London Executive Council published a list on 1st April, 1949 and another in 1st July, 1951. Both dates fall within the triennium. The 1949 list, showing 1,407 doctors practising in the South of the County of London, has been used as a basis for the year 1949; the 1951 list showing 1,460 doctors (a difference of 53) is used for the years 1950 and 1951.

It will be seen from Table 84 that:

(1) Of the 1,460 doctors practising in South London in 1951, 428 (29 per cent: less than a third) sent patients to the Joint Hospital (line c).

(2) More doctors practising in S.E. London (260 doctors out of 651, or 40 per cent: line a) referred patients to the Joint Hospital in 1951 than did doctors practising in S.W. London (168 out of 809, or 21 per cent: line b).

(3) In the three years under consideration a slightly increased proportion of doctors in both districts referred patients to the Joint Hospital. If the doctors in both districts are taken together, the percentages are as follows: 1949—26.1; 1950—27.3; 1951—29.0 (line c, last 3 columns).

Table 85 shows the distribution of doctors by the number of patients they referred to us. It will be seen how widely their habits varied. The most sensational feature of the table is a doctor in the S.W. district who, in 1951, referred to us no less than 43 patients. This doctor sent us in that year more than twice as many patients as any doctor had sent us in any of the three years 1949 to 1951.

	No. of Doctors			No. of Patients		
Year	1949	1950	1951	1949	1950	1951
Numbers	143	149	158	721	870	936
Per cent.	39	37	37	71	72	72

Table 86. *Numbers of Doctors practising in S.E. and S.W. Postal Districts of London who referred Three or More Patients to the Joint Hospital in the Years* 1949, 1950 *and* 1951; *and the Numbers of Patients they referred. For explanation of Percentages see Text.*

Table 86 brings out the main feature of Table 85, namely that a minority of referring doctors practising in South London sent to the Joint Hospital, through multiple referrals, a majority of its South London patients.

In 1951 72 per cent of South London patients were referred by 37 per cent of South London doctors who referred patients. There has been little change in these percentages in three years.

These figures well illustrate how the volume of patients seen at a hospital is influenced by the referring habits of doctors. The matter can be summed up as follows:

In South London (County of London Area) there were practising, in 1951, 1,460 doctors. Of these only 428 (or 29 per cent) sent patients to the Joint Hospital. Of these 428 doctors 158 sent to the Hospital 72 per cent of its South London patients.

From the figures, it follows that 10.8 per cent of doctors practising in South London (County of London Area) sent to the Hospital, in 1951, 72 per cent of its South London patients; it also follows that, if all the doctors practising in the County of London Area of South London were to acquire the habits of these 10.8 per cent, the number of patients referred to the Hospital would be increased by *more than six-fold*.

It is, of course, certain that doctors living in South London refer psychiatric patients to other hospitals. Many doubtless favour Guy's, King's College or other hospitals. The number of psychiatric cases referred to hospitals by doctors in South London could only be ascertained by a difficult compilation and comparison of data from all London hospitals possessing psychiatric departments.

Such a compilation might show that practitioners varied less in their habits of referring psychiatric patients to hospital than our figures suggest.

But it nevertheless remains highly probable that the figures given in Tables 85 and 86 reflect a wide variety of attitude among practitioners towards psychiatric patients; also a wide range of confidence in the efficacy of psychiatric treatments.

It may be worth noting in this connection that a survey conducted in a Midland city during 1942 and 1943 showed that only 10 per cent of doctors practising in that city had, in those two years, ever referred patients to the city's psychiatric clinics.

APPENDIX

EXTRACT FROM THE INTERNATIONAL LIST OF DISEASES AND CAUSES OF DEATH (GENEVA, OCTOBER, 1947)

MENTAL, PSYCHONEUROTIC AND PERSONALITY DISORDERS

This section (300-326) excludes transient delirium and minor mental disturbances accompanying definitely physical disease. Examples of this kind are transient delirium of febrile reaction, transient intoxication with uræmia, transient mental reactions with any systemic infection, or with brain infection, trauma, degenerative disease, or vascular disease.

PSYCHOSES (300-309)

Numbers 300-309 exclude: juvenile neurosyphilis (020.1), general paralysis of insane (025), postencephalitic psychosis (083.2), and puerperal psychosis (688.1).

300 Schizophrenic Disorders (Dementia Praecox)

300.0 *Simple type*

Dementia:
Primary
simplex

Schizophrenia:
Primary
simple

300.1 *Hebephrenic type*

Dementia, paraphrenic
Hebephrenia
Paraphrenia

Schizophrenia:
hebephrenic
paraphrenic

300.2 *Catatonic type*

Catatonia
Dementia, catatonic

Schizophrenia, catatonic

300.3 *Paranoid type*

Dementia, paranoid

Schizophrenia, paranoid

300.4 *Acute schizophrenic reaction*

Schizophrenic reaction, acute

300.5 *Latent schizophrenia*

Latent schizophrenic reaction
Schizophrenia, latent

Schizophrenic residual state (Restzustand)

300.6 *Schizo-affective psychosis*

Mixed schizophrenic and manic-depressive psychosis
Schizo-affective psychosis
Schizothymia

Note: NOS (which appears on most of the ensuing pages) means *Not otherwise specified.*

300.7 *Other and unspecified*

Dementia præcox
Schizophrenia
Schizophrenic reaction
} NOS or any type not classifiable under 300.0-300.6

301 Manic-depressive reaction

This title excludes neurotic depressive reaction (314).

301.0 *Manic and circular*

Insanity of psychosis, manic-depressive:
  circular
  manic

Alternating insanity
Circular:
  insanity
  stupor
Cyclothymia
Hypomania
Mania NOS
Manic-depressive reaction:
  agitated
  Circular
  manic

301.1 *Depressive*

Insanity or psychosis, manic-depressive, depressive
Manic-depressive reaction, depressive
Melancholia NOS

301.2 *Other*

Affective psychosis
Insanity or psychosis, manic-depressive:
  NOS
  any typle except circular, depressive, or manic
Manic-depressive reaction:
  NOS
  stuporous

302 Involutional melancholia

Insanity, climacteric
Melancholia:
  climacteric
  involutional
  menopausal
Psychosis, involutional (any type)

303 Paranoia and paronoid states

Paranoia
Paranoid conditions, other than in dementia and schizophrenia
Paranoid state, NOS

304 Senile psychosis

Cerebral atrophy or degeneration with psychosis at ages 65 and over
Dementia of old age
Senile:
  dementia
  imbecility
  insanity
  melancholia
  psychosis (any type)

305 Presenile psychosis

Alzheimer's disease
Circumscribed atrophy of brain
Pick's disease of brain
Presenile:
  dementia
  psychosis
  sclerosis

306 Psychosis with cerebral arteriosclerosis*

Dementia, arteriosclerotic
Organic brain disease with psychosis
Psychosis due to arteriosclerosis (cerebral)

307 Alcoholic psychosis

Delirium tremens
Hallucinosis, alcoholic
Korsakoff's psychosis or syndrome, unless specified as non-alcoholic
Polyneuritic psychosis, alcoholic
Psychosis, alcoholic (any type)

This title excludes alcoholic addiction without psychosis (322).

308 Psychosis of other demonstrable etiology*

308.0 *Resulting from brain tumour*

Psychosis:
  resulting from brain tumour
  with intracranial neoplasm

308.1 *Resulting from epilepsy and other convulsive disorders*

Epileptic:
  clouded state
  deterioration

Psychosis with:
  any condition classifiable under 353
  other convulsive disorders

This title excludes epilepsy without psychosis (353).

308.2 *Other*

Psychosis secondary or due to any disease or injury not classifiable under 308.0-308.1.

309 Other and unspecified psychosis

Cerebral atrophy or degeneration with psychosis, ages under 65, not specified as presenile dementia
Dementia NOS
Deterioration, mental
Exhaustion delirium
Insanity NOS
  confusional
  delusional

Psychosis NOS, or any type not classifiable under 020.1, 025, 083.2, 300-308, 688.1.

PSYCHONEUROTIC DISORDERS (310-318)

Numbers 310-318 exclude simple adult maladjustment (326.4) and nervousness and debility (790).

310 Anxiety reaction without mention of somatic symptoms

Anxiety:
  neurosis NOS
  reaction NOS
  state NOS

Anxiety reaction with any condition in 311 without mention of somatic symptoms

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* Numbers 306 and 308 are not to be used for primary death classification if the nature of the poisoning, injury or antecedent cause is known, and will not generally be used for primary morbidity classification if the antecedent condition is present.

311 Hysterical reaction without mention of anxiety reaction

Anorexia nervosa
Compensation neurosis
Dissociative reaction (any)
Hysteria, hysterical:
- NOS
- amnesia
- anæsthesia
- anorexia
- anosmia
- aphonia
- blindness
- catalepsy
- conversion

} without mention of anxiety reaction

Hysteria, hysterical:
- convulsions
- dyskinesia
- fugue
- mutism
- paralysis
- postures
- somnambulism
- tic
- tremor
- other manifestations

Hystero-epilepsy

} without mention of anxiety reaction

312 Phobic reaction

Fear reaction
Phobia NOS
Phobic reaction

313 Obsessive-compulsive reaction

Neurosis:
- compulsive
- impulsive
- obsessional
- obsessive-compulsive

Obsessional:
- ideas and mental images
- impulses
- phobias
- ruminations
- state

Obsessive-compulsive reaction

314 Neurotic depressive reaction

Neurotic depressive reaction
Psychogenic depression
Reactive depression

This title excludes manic-depressive reaction (301).

315 Psychoneurosis with somatic symptoms (somatization reaction) affecting circulatory system

This title excludes functional heart disease (433) unless specified as psychogenic.

315.0 *Neurocirculatory asthenia*

Cardiac asthenia
Da Costa's syndrome
Disordered action of heart, specified as psychogenic
Effort syndrome
Neurocirculatory asthenia
"Soldier's heart"

315.1 *Other heart manifestations specified as of psychogenic origin*

Functional heart disease, specified as psychogenic
Any condition in 433 specified as psychogenic, but not classifiable under 315.0

315.2 *Other circulatory manifestations of psychogenic origin*

Disorder of cardiovascular system specified as psychogenic but not classifiable under 315.0 or 315.1

316 Psychoneurosis with somatic symptoms (somatization reaction) affecting digestive system.

This title excludes ulcer of stomach (540) and of duodenum (541). It excludes functional disorders of œsophagus (539.0), of stomach (544), and of intestines (573) unless specified as psychogenic.

316.0 *Mucous colitis specified as of psychogenic origin*

Any condition in 573.1 specified as psychogenic.

316.1 *Irritability of colon specified as of psychogenic origin*

Functional diarrhœa, specified as psychogenic.
Any condition in 573.2 specified as psychogenic.

316.2 *Gastric neuroses*

Cyclical vomiting
Functional dyspepsia, specified as psychogenic
Gastric neurosis
Any condition in 544 specified as psychogenic

316.3 *Other digestive manifestations specified as of psychogenic origin*

Aerophagy
Disorder of digestive system specified as psychogenic, but not classifiable under 316.0-316.2.
Globus

317 Psychoneurosis with somatic symptoms (somatization reactions) affecting other systems

317.0 *Psychogenic reactions affecting respiratory system*

Disorder of respiratory system, specified as psychogenic
Psychogenic asthma

317.1 *Psychogenic reactions affecting genito-urinary system*

Disorder of:
genito-urinary system
micturition
sexual function
} specified as psychogenic

317.2 *Pruritus of psychogenic origin*

Pruritus, specified as psychogenic

317.3 *Other cutaneous neuroses*

Disorder of skin specified as psychogenic, excluding pruritus

317.4 *Psychogenic reactions affecting musculo-skeletal system*

Disorder of:
articulation (joint)
joint
limb
muscle
musculo skeletal system
} specified as psychogenic
Paralysis

317.5 *Psychogenic reactions affecting other systems*

Disorders of parts of body not classifiable under 315-317.4, specified as psychogenic

318 Psychoneurotic disorders, other, mixed, and unspecified types

318.0 *Hypochondriacal reaction*

Hypochondria
Hypochondriasis

318.1 *Depersonalization*

Depersonalization

318.2 *Occupational neurosis*

Craft neurosis
Occupational neurosis
Miner's nystagmus

318.3 *Asthenic reaction*

Asthenic reaction
Nervous:
debility
exhaustion
prostration
Neurasthenia
Psychogenic:
asthenia
general fatigue

318.4 *Mixed*

Psychoneurotic disorders, mixed
This title excludes mixed anxiety and hysterical reactions (310)

318.5 *Of other and unspecified types*

Nervous breakdown
Neurosis NOS
Psychasthenia
Psychoneurosis:
NOS
Other specified types not classifiable under 310-318.4

DISORDERS OF CHARACTER, BEHAVIOUR AND INTELLIGENCE (320-326)

Numbers 320, 321, 325, 326 exclude residuals of acute infectious encephalitis (083).

320 Pathological personality

320.0 *Schizoid personality*

Schizoid personality

320.1 *Paranoid personality*

Paranoid personality
This title excludes paranoia and paranoid states (303).

320.2 *Cyclothymic personality*

Cyclothymic personality

320.3 *Inadequate personality*

Constitutional inferiority
Inadequate personality NOS

320.4 *Antisocial personality*

Antisocial personality
Constitutional psychopathic state
Psychopathic personality: NOS
with antisocial trend

320.5 *Asocial personality*

Asocial personality
Moral deficiency
Pathological liar
Psychopathic personality with amoral trend

320.6 *Sexual deviation*

Exhibitionism
Fetishism
Homosexuality
Pathologic sexuality
Sadism
Sexual deviation

320.7 *Other and unspecified*

Pathological personality NOS

321 Immature personality

321.0 *Emotional instability*

Emotional instability (excessive)

321.1 *Passive dependency*

Dependency reactions
Passive dependency

321.2 *Aggressiveness*

Aggressiveness

321.3 *Enuresis characterizing immature personality*

Enuresis specified as a manifestation of immature personality

312.4 *Other symptomatic habits except speech impediments*

Symptomatic habits other than enuresis and speech impediments, specified as manifestations of immature personality

321.5 *Other and unspecified*

Immature personality NOS

Immaturity reaction NOS

322 Alcoholism

This title excludes alcoholic psychosis (307), and acute poisoning by alcohol (E880, N961). For primary cause classification it excludes cirrhosis of liver with alcoholism (581.1).

322.0 *Acute*

Alcoholism, acute

Ethylism, acute

322.1 *Chronic*

Alcoholic addiction
Alcoholism, chronic

Ethylism, chronic

322.2 *Unspecified*

Alcoholism NOS

Ethylism NOS

323 Other drug addiction

Addiction to, or chronic poisoning by:
- amphetamine
- barbituric acid (and compounds)
- benzedrine
- bromides
- cannabis indica
- chloral
- cocaine
- codeine
- demerol
- diacetylmorphine
- diamorphine
- ethylmorphine

Addiction to, or chronic poisoning by:
- hashish
- heroin
- Indian hemp
- morphine
- opium
- paraldehyde
- pethedine
- thebaine
- other narcotic, analgesic and soporific drugs

Drug addiction
Morphinism

324 Primary childhood behaviour disorders

Behaviour disorder of childhood not identified with psychopathic personality, mental deficiency, or any physical illness:
- jealousy
- masturbation
- tantrum

Juvenile delinquency

This title excludes personality disorders (320-321)

325 Mental deficiency

This title excludes, cerebral spastic infantile paraplegia (351); birth injury (760, 761): epiloia, tuberose sclerosis (753.1); gargoylism (289); hydrocephalus (344 and 752); hypertelorism (758.2); juvenile general paralysis of the insane (020.1).

325.0 *Idiocy*

Idiocy (congenital) NOS

Idiot
- adult of mental age 0-2 years
- child with I.Q. under 20

325.1 *Imbecility*

Imbecile
- adult with mental age 3-7 years
- child with I.Q. 20-49

Imbecility NOS

325.2 *Moron*

Amentia
Feeble mindedness
High grade defect

Moron
adult with mental age 8-12 years
child with I.Q. 50-69

325.3 *Borderline intelligence*

Backwardness

Borderline intelligence
Deficientia intelligentiæ

325.4 *Mongolism*

Mongolian idiocy

Mongolism

325.5 *Other and unspecified types*

Amaurotic family idiocy
Cerebro macular degeneration
Mental deficiency NOS
Mental retardation NOS

Oligophrenia
Phenylpyruvic oligophrenia
Tay-Sachs disease

326 Other and unspecified character, behaviour, and intelligence disorders

326.0 *Specific learning defects*

Specific learning defects (reading) (mathematics) (strephosymbolia)

326.1 *Stammering and stuttering of non organic origin*

Stammering or stuttering:
NOS
due to specified non-organic cause

This title includes any condition in 781.5 of unspecified or non-organic origin

326.2 *Other speech impediments of non-organic origin*

Any speech impediment, not in 326.1:
NOS due to specified non-organic cause

This title includes any condition in 781.6 of unspecified or non-organic origin

326.3 *Acute situational maladjustment*

Abnormal excitability
under minor stress
Acute situational maladjustment

Combat fatigue
Operational fatigue

326.4 *Other and unspecified*

Simple adult maladjustment

Primary behaviour disorders and psychoneurotic personalities not classifiable under 083, 310-318, 320-326.3.

***327 Diagnosis uncertain**

***328 No psychiatric abnormality**

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* Numbers 327 and 328 are not comprised in the International List. They have been included to meet the hospital's needs. They should be used for out-patients only.

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